Stigmatization of Condom Use amongst Educated Medical Staff: A Practical Theological Approach

Tarbi Prinsloo

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Supervisor: Prof DJ Louw

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ABSTRACT

Tarbi Prinsloo, Department of Practical Theology, Faculty of Theology, University of Stellenbosch, Stellenbosch

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The aim of this thesis is to identity whether condoms are being stigmatized, and to investigate the current perceptions, attitudes and beliefs about condom use in relation to the HIV and AIDS epidemic.

Through the use of Richard Osmer's model for research in Practical Theology, the study starts off with a Descriptive-Empirical task to investigate what is going on regarding the impact of society's perceptions on condom use. The second part of the study commences the Interpretive task investigating why the perceptions about condoms exist, exploring the impact and dynamics of stigmatization; looking at sex, sexuality, sin and taboos relative to stigmatization. The Normative task explores what ought to be the perceptions of condom use by using Louw's (2008) theory, an integrative Christian spiritual approach to Sexual Ethics, to explore the sacred space of sexuality, evaluating human sexuality and the human body, also looking at marriage and sexuality. Lastly, the Pragmatic task looks at the possible ways that we might respond to stigmatization, recommending certain practical conclusions within a pastoral counselling view to move towards de-stigmatization. These approaches include discussion on relevant HIV education and awareness programmes, pastoral care and counselling methods and programmes for people living with HIV and AIDS, and a pastoral approach with a Jesus as model for pastoral counselling. These collectively and conclusively explain the paradigm shift of letting the theology of the resurrection state a theological critique on stigmatization.

In conclusion, the thesis argues that people do hold stigmatized perceptions about condoms and HIV and AIDS and these perceptions are grounded in attitudes and beliefs that are products of cultural and religious societal processes. The study proved that educational interventions need to be adapted to be more contextually relevant in order to be effective as a practical approach to stigmatization, as the study proved that having medical, educational knowledge about HIV and AIDS and prevention interventions do not necessarily result in saver sexual practice. Ultimately, pastoral approaches should be implemented in the hope to offer a movement towards de-stigmatization, not only of condoms, but HIV and AIDS and people living with HIV and AIDS. Thus, the proposal for a pastoral spiritual approach in process of de-stigmatization based upon a theological model. In this regard, the theological model is based on the notion of the *theologia resurrectionis*.

OPSOMMING

Tarbi Prinsloo, Departement Praktiese Teologie, Fakulteit Teologie, Universiteit van Stellenbosch, Stellenbosch

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Stigmatisering van die gebruik van kondome onder opgeleide mediese personeel: 'n Praktiese teologiese benadering

Die doel van hierdie tesis is om te identifiseer of kondome gestigmatiseer word en om die huidige persepsies, houdings en oortuigings oor die gebruik van kondome, met betrekking tot die MIV- en VIGS-epidemie, te ondersoek.

Deur die gebruik van Richard Osmer se model vir navorsing in Praktiese Teologie, begin die studie begin met 'n beskrywende-empiriese taak om te ondersoek wat die impak van die gemeenskap se persepsies is oor die gebruik van kondome. Die tweede deel van die studie, die interpretatiewe taak, ondersoek waarom die persepsies oor kondome bestaan. Dit ondersoek ook die impak en dinamika van stigmatisering deur te kyk na seks, seksualiteit, sonde en die taboes relatief tot stigmatisering. Die normatiewe taak ondersoek wat die persepsies van kondom gebruik behoort te wees deur Louw se (2008) se teorie, 'n geïntegreerde Christelike geestelike benadering tot seksuele etiek, te raadpleeg. Daardeur kyk die studie na die sakrale ruimte van seksualiteit en evalueer menslike seksualiteit en die menslike liggaam asook die huwelik en sexualiteit daarvolgens. Laastens in die pragmatiese taak kyk die study na die moontlike maniere waarop ons kan reageer op stigmatisering. Die pragmatiese taak beveel sekere praktiese gevolgtrekkings binne 'n pastorale beradings oogpunt aan, as ‘n moontlike kopskuif na ‘de’-stigmatisering. Hierdie benaderings sluit in; bespreking van relevante MIV opvoeding en bewusmaking programme, pastorale sorg en berading metodes en programme vir mense wat lewe met MIV en VIGS en ook 'n pastorale benadering met Jesus as model vir pastorale berading. Gesamentlik verduidelik hierdie moontlike benaderings die paradigmaskuif na die opstandingsteologie en 'n teologiese kritiek op stigmatisering.

Ten slotte, argumenteer die studie dat mense gestigmatiseerde persepsies oor kondome en MIV en VIGS het en hierdie persepsies is gegrond in houdings en oortuigings wat die produk is van kulturele en godsdienstige maatskaplike prosesse. Die studie het bewys dat opvoedkundige ingrypings moet aangepas word om meer kontekstueel relevant te wees ten einde doeltreffend as 'n praktiese benadering tot stigmatisering te dien. Aangesien die studie ook bewys dat mediese, opvoedkundige kennis oor MIV en VIGS en die voorkomende ingrypings daarvan nie noodwendig lei tot veiliger seksuele gedrag nie. Van daar die aksent op ‘n pastoraal-spirituele benadering in prosesse van ‘de’-stigmatisering wat teologies vernader is na ‘n opstandingsperspektief. Die laasgenoemde kan bydra tot ‘n meer integrale antropologie in pastorale hulpverlening. Daar word uiteindelike gehoop dat hierdie pastorale benaderings geïmplementeer kan word om die kopskuif te maak na ‘de’-stigmatisering.

DEDICATIONS:

Firstly I would like to dedicate this study to my parents, Chris and Ria. I want to thank you for your patience, your willingness to listen and financial support throughout all of my years of study. Thank you for always engaging with me in the teachings of Christianity. Also to my sister Tarien, thank you for your presence in my life.

Secondly, I would like to dedicate this study to Devin. Thank you for all of your support, patience and encouragement through my years of study and research. I appreciate you and love you deeply.

I would also like to dedicate this research to all of the educators in my lifetime, as applied knowledge *is* power, and my knowledge, as one of my most prized possessions, can never be removed from me and has formed me and my thoughts. Thank you for being the contributors to my knowledge acquisition.

Lastly, I would like to dedicate this study to the Almighty God. Glory to God!

DECLARATION:

Through electronic submission of this thesis, I, Tarbi Prinsloo, would herewith like to declare that the entirety of the work contained herein is my own, original work and that I am the sole author thereof (except in the extent explicitly otherwise stated). The re-production and publication of this thesis by the University of Stellenbosch would not violate any third party rights. I further declare that I have not previously submitted any part, or whole, of this document in order to obtain any qualification.

Date: 1 December 2014

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Since the disease was first identified in the early 1980's, the scourge of what is known as HIV and AIDS has been with human societies across the globe for nigh on 35 years. Although the virus appears stable in most countries globally, Sub-Saharan Africa still accounts for 71% of the world's HIV infections as indicated in 2009, therefore being the most affected region in the world (Van Dyk, 2012: 7). The HI-Virus is a frightening reality in South Africa and its dissemination has worsened to the extent that in South Africa it is no longer referred to as an epidemic, but it has become almost commonplace to hear of the pandemic of HIV and AIDS (Pick, 2006: 3). There is not a village, town or city where people are not dying of AIDS or an HIV-related illness and conservative estimates are that out of the 5-6 million or so sufferers in South Africa, one in every five are hospitalised (Van Dyk, 2007:49; Solomons, 2013:1). The majority of sufferers die of even the most common illness – a cold or smallpox for example – simply because one cannot recover due to a devastated immune system. In light of this research, it will be referred to as the HIV and AIDS epidemic as one does not want to enforce any stigma on the argument throughout the study.

Various efforts to try and combat the spread or at least to curb the terrible toll of HIV and AIDS to some extent have been invented and implemented from an early stage. For example, testing blood for blood transfusions, the prevention of mother to child transmission (pMTCT), the treatment of sexually transmitted infections (STI's), and promotion of lifestyle change concerning safer sexual behaviours (ed. Visser, 2007: 192). One of these lifestyle changes is 'condomization' – to promote the use of condoms not only by people who maintain a promiscuous sexually active lifestyle with many sex partners of both genders, but also by people who contracted the disease to protect the marriage partners. Condom distribution and information on how to use condoms is considered a means to reduce high risk sexual behaviour, but Visser explains that knowledge about high risk behaviour is not enough to influence individual decision making (2007:193). This could be ascribed to numerous other factors influencing on the individual's decisions. Joubert-Wallis and Fourie explain that the behaviour of the indi-

vidual is influenced by cultural beliefs and traditions of their community and these beliefs cannot simply be altered by education or knowledge about HIV and other health related issues (2009:107). It is believed that individual skill and knowledge training is therefore not enough to change individual behaviour, as individual sexual behaviour is shaped by cultural beliefs and the meanings societies attach to relationships, protective measures and gender roles (ed. Visser: 2007: 193). The exploration of these attitudes and beliefs might assist in identifying whether the message of 'condomization' is effective - what the perceptions are surrounding condoms in societies and how these perceptions are implicating other interlinking beliefs and attitudes. The question can be raised, how much education and knowledge is enough to evoke behavioural change?

Taylor explains that the knowledge of safe sex and having the belief that one is capable of engaging in safe sex does not necessarily result in safer sexual behaviour, as behaviour is governed by the attitudes and perceptions in a culture and individuals make choices when functioning in their environment (2009: 378). Thus, people's attitudes, beliefs and perceptions are impacting on the course of the HIV epidemic, as the epidemic is influenced by factors: people's expressions of sexuality, drug and alcohol use, the media, responses of the government to the epidemic and disease, and also the society's comprehension of the seriousness of the epidemic. Stigmatization and denial can often be a product of people's view of the epidemic and can also be a considered a product of socially constructed contexts (Balcomb, 2006: 104). Considering the magnitude of the epidemic, it is clear that the evaluation of social systems and contexts, beliefs, behaviours, institutions and any other construct should be linked to the cultural reference and context (Joubert-Wallis & Fourie, 2009:106).

Consequently, it becomes clear that research needs to investigate the current attitudes, beliefs and perceptions about condoms and the HIV and AIDS epidemic, in order to discern the impact thereof on the HIV and AIDS epidemic. In light of the aforementioned, the aim of this research study is therefore to investigate attitudes, beliefs and perceptions held in social contexts and to explore whether the use of condoms as preventative intervention is being stigmatized and whether or not this stigmatization is impacting the HIV and AIDS epidemic?

1.2 BACKGROUND

One of the main educational functions of healthcare workers is to encourage changes in unsafe sexual behaviour and drug use. Evidence from around the world has confirmed that well-designed and skilfully executed prevention programmes can reduce the incidence of HIV (Van Dyk, 2012: 166). Studies have shown that behavioural interventions, such as information, education and communication programmes, condom promotion programmes and alternate behavioural change initiatives can result in individuals changing high-risk sexual behaviour (Van Dyk, 2012: 166).

The most common means of transmission of HIV is through sexual intercourse or contact with infected blood, semen or cervical and vaginal fluids. Sexual transmission can occur vaginally, orally or anally (Van Dyk, 2012: 166). Apart from abstinence and serial monogamy, barrier methods - such as latex and polyurethane condoms - are the most effective way to reduce sexual transmission of HIV and other infections (Van Dyk, 2012: 166).

Condoms are not very popular in Africa and are not always seen as a preferred method of prevention against HIV, regardless of the increased global awareness of HIV and AIDS (Van Dyk, 2012: 225). Taylor mentions that knowledge about prevention interventions and HIV and AIDS does not necessarily mean that people will start engaging in safer sexual practice (2009: 378). Thus, one could investigate whether people with medically trained knowledge about HIV and AIDS, and the relevant prevention methods, might not be more likely to use condoms. There might be some underlying reason as to why condoms are not being used as a preferred prevention method in Africa. Throughout this research, the investigation of this might bring forth some enlightenment.

Gillies, Tolley and Woltenholme explain that Sub-Saharan Africa struggles with third world poverty, where the Sub-Saharan Africa region has the lowest levels of GNP, or Gross National Product – a means by which poverty is measured, per capita in 1991 (2000: 201). Gilles *et al.* (200: 201) further determined that HIV and AIDS case rates are higher in poorer African countries than in wealthier European countries. Thus, Gilles also deducts that poorer people are affected worse by HIV and AIDS (more of this discussed under 2.3.1.2 of this study) (Gillies *et al*. 2000: 204).

The United Nations Development Programme South Africa (UNDP SA) (2003) reported that the number of South Africans living on less than $1 a day has increased by 1 million people from 1995 to 2002. Poverty is not only associated with unemployment, but also with low levels of education, social vulnerability and weakened resistance to diseases, such as HIV and AIDS. Therefore, poverty influences the lifestyle, educational and social life of individuals and communities (Visser, 2007: 218-219).

Poor people lack adequate resources to good HIV and AIDS education and health-care (Joubert-Wallis & Fourie, 2009: 114-115). Louw mentions that structural and systemic factors such as poverty and inappropriate economic policies and medical care are also contributing to the epidemic. Clear deductions can be formed about poverty and its strong relation to HIV and AIDS and education. Herewith, one might be able to draw a hypothesis: if it is determined that medically trained staff members, that have educated knowledge about HIV and AIDS and preventative interventions thereof, do hold stigmatised perceptions about condoms. One might then be able to hypothesize that a poor uneducated sample group might have even stronger held perceptions, attitudes and beliefs towards condoms and might be even less likely to use condoms as a preventative intervention.

1.3 RESEARCH PROBLEM

Considering the above, a few questions regarding condoms and other preventative interventions can be identified. For instance, what are the perceptions surrounding preventative interventions and why do these exist? Further, one must investigate the kind of education and information that is made available about HIV and AIDS and preventative interventions. This begs the question, how accessible is contextually relevant education interventions for Africa? In other words, in what contexts are prevention methods being communicated and are they available and accessible for everyone? If information, knowledge and education on HIV and AIDS and prevention interventions are communicated in predisposed stigmatized contexts, what value does the information have for the person receiving it? People educating others or giving information on the topic of HIV and AIDS might have developed certain perceptions and opinions about HIV and AIDS and these perceptions often impact one's ability to teach another on the topic, as personal beliefs and attitudes can be communicated concurrently.

In formulating the research problem, a few explorative questions can be identified as the investigative guide through the study: First, are condoms being stigmatized, if so, why? Second, could the stigmatization of condoms be a result of the stigma surrounding the HIV and AIDS epidemic or could it be seen as instigating HIV and AIDS related stigmatization? Third, should it be identified that condoms are being stigmatized, can this stigmatization be ascribed to poor education only, or does ignorance also play a role?

These questions lead the study into the investigation of the attitudes, beliefs and perceptions surrounding condoms, in order to fully comprehend if and why condoms are unpopular and whether current educational and information distribution methods are appropriate in relation to the magnitude of the HIV and AIDS epidemic. The ultimate research question of this study is then; what are the true perceptions of condoms in relation to HIV and AIDS?

1.4 METHOD

The methodology of this thesis is an epistemological endeavour, taking the form of first a literature review, then attending formally to the research through an empirical study and thereafter, the research develops the argument further through the use of a Hermeneutical literature review. Though the epistemological endeavour takes this shape, the entire research study uses Richard Osmer's (2008) Practical Theological methodology as a model for the epistemological endeavour, for the purpose of orderly research. Although intended primarily for congregational as effective interpretive guides for their congregations, the model is also ideally suited for academic research (Osmer, 2008:4-5). Osmer's methodology helps to engage in practical theological interpretation and the method comprises of four 'tasks' to interpret episodes, situations and contexts theologically (2008: 4-5). It can be presented thus:

Diagram 1.1: Richard Osmer's methodology for research

Task	Descriptive-Empirical task	Interpretive	Normative	Strategic
Question	What is going on?	Why is it going on?	What ought to be going on?	How might we respond?
Function	Priestly listening	Sagely wisdom	Prophetic discernment	Servant leadership

These four tasks are cursorily put in perspective (Osmer: 2008: 4).

Osmer's methodology for Practical Theology was chosen for this research study because the methodology particularly allows for an empirical component of formal attending. Osmer explains that 'it helps to conceptualise the relationship between the spirituality of presence and the Descriptive-Empirical task of practical theological interpretation along the lines of a continuum' (Osmer, 2008: 37). The continuum follows from informal attending, to semi-formal attending and then formal attending. For the epistemological endeavour of this research, the use of formal attending through an empirical study allows for the investigation of particular episodes, situations and contexts through empirical research (Osmer, 2008: 37). Osmer even refers to the work of Tisdale, explaining that empirical enquiry might enlighten one's ability for priestly listening (2008: 38). Empirical methods allows for practical theologians to attend to others in a systemic and intentional fashion. Some criticize that empirical research can objectify people, but Osmer argues that it is not always the case, as it allows researchers to deepen their understanding of what is going on in particular episodes, situations and contexts (2008: 39). In accordance with Osmer's methodology and with relevance to this research, the empirical research in the Descriptive-Empirical task allows for a deepened understanding of what is going on with regards to the perceptions that are held about condom use. Thus, the empirical component of the epistemological endeavour proves to be particularly helpful in allowing interpretive guides to better understand the participants in the research as it assists in the interpretation and identification of trends that are impacting people's lives and shaping their context (Osmer, 2008: 41). The intention is that the formal attending in this research study might assist in the identification and interpretation of people's perceptions about condom use, the exploration of these perceptions, and how they are relevant to the phenomenon of HIV and AIDS. It

offers a vantage point from which to interpret what is going on with regards to the perceptions people have about condom use and further assists in the formulation of the argument of the research study (Osmer, 2008: 42).

According to Osmer, formal attending allows the researcher to deepen their understanding of a crisis in the life of an individual, family and congregation, or local community. It allows for a better understanding of the culture of the community and assists in developing a better understanding of the context of the community. It further allows for the comprehension of contexts of different groups in the community (Osmer, 2008: 47). The Descriptive-Empirical task initiates this phenomenological research study with the initial probing research question, what is going on with regards to the perceptions of condom use, within the phenomenon of HIV and AIDS (Osmer, 2008: 52)?

1.4.1 Descriptive-Empirical task: What is going on?

It is no secret that the HIV and AIDS phenomenon is immensely influenced by stigma, discrimination and ignorance. Numerous interventions have been implemented worldwide in an attempt to create awareness, inform ignorance and de-stigmatize HIV and AIDS. To attend to what is going in regarding the HIV and AIDS phenomenon, it would be necessary to gain perspective on how far the stigma surrounding HIV and AIDS actually stretches, also determining whether educational interventions for HIV and AIDS are informative enough to combat the stronghold of the ignorance surrounding HIV and AIDS.

In the execution of this task, it was investigated whether the use of condoms as preventative intervention is being stigmatized and whether or not this stigmatization is impacting on the HIV and AIDS epidemic humanity faces in life and practice.

This topic was engaged in with a literature review and to answer the following research questions; are condoms being stigmatized? If so, is the stigmatization of condoms a result of the stigma's surrounding HIV and AIDS or is it fuelling the stigma surrounding HIV and AIDS? Is the stigma associated with HIV and AIDS and condom use a result of ignorance or poor education on the subject? Can a means be developed to effectively educate people to move from ignorance towards a consciousness of de-stigmatization?

1.4.1.1 The Empirical Component

The Descriptive-Empirical task went out from the proposition that education is an empowerment tool in the battle against HIV and AIDS, but it is not necessarily effective in moving toward the de-stigmatization of HIV and AIDS. This presupposition served as guidance in the initial literature review to determine what is going on regarding perceptions about condoms. Closely aligned with the first proposition is the possibility that knowledge about HIV and AIDS does not necessarily mean that one would use a condom to prevent sexual exposure to the HI-Virus. The question is whether educational interventions about HIV and AIDS and knowledge about the benefits of using condoms during sexual intercourse translate into condom use as a preventative measure during sexual intercourse. Do individuals that possess medical knowledge about the benefits of condoms actually practice condom use to prevent the spread of HIV and AIDS? If not, why not? The empirical study therefore attends to the perceptions of condom use amongst educated medical staff.

As the question 'what is going on?' was explored, these notions morphed into a more formal, attending focus to facilitate a diagnosis of what goes on. To use the word 'diagnosis/diagnostic' to describe the empirical task would be appropriate under Osmer's methodology. Diagnosis has to do with thorough examination to arrive at a verdict to access and assess a problem from all possible angles (Osmer, 2008: 16). The hope is that the empirical study will supplement the explorations surrounding perceptions and attitudes from a quantitative and objective point of view. To understand their influence on how people view condoms and how people understand HIV and AIDS. Assisting in attending formally to the first research question mentioned above.

With this in mind, post-exploration of the initial literature, the Descriptive-Empirical task allows for a more formal attentiveness to the same question in order to deepen the understanding of what is going on with regards the perceptions of condom use and its relation to the phenomenon of HIV and AIDS (Osmer, 2008: 4-5).

Should the empirical study deepen one's understanding about the possible stigmatized perceptions educated medical staff hold about condoms use, one could pose the hypothesis that uneducated communities might have even stronger held perceptions about condoms and might be even less likely to use a condom. This poses the opportunity for further study with relevance to this research.

1.4.2 Interpretive task: Why is it going on?

In order to know how to respond to the observed phenomena, it has to be understood why perceptions about condoms exist. The Interpretive task explored in this research question, must be accompanied by critical judgement and argumentation, as well as reflection from relevant perspectives (Osmer 2008: 83).

A hermeneutical literature review was implemented to investigate and derive insight from the phenomena observed in the Descriptive-Empirical task. The interpretive section of the hermeneutical literature review investigated the attitudes and beliefs people hold about condoms and wherein these attitudes and beliefs are grounded. The aspects of culture and religion are realities that influence the attitudes and beliefs, and must thus also be identified.

Throughout the Interpretive task, the notions of stigma, stigmatization and the dynamics surrounding stigma were kept in mind. The exploration of stigmatization within a hermeneutical literal structure includes discussion of what stigma is and why it exists through the exploration of texts and literature pertaining to the topic, also looking at the parallels between stigma, shame, denial, discrimination, miss-action and inaction when it comes to HIV and AIDS, and the functioning of stigmatization as a social process and symbolic threat were considered.

Given the dire and utterly negative 'aura' that surrounds HIV/AIDS, it was also necessary to explore stigma in relation to variables of sin and sex and to look at the Christian discourses that might be contributing to stigma. A last aspect was to try and gauge how post colonialist influences might have had an effect on stigmatization. By drawing from theories formulated by other researchers, the hermeneutical literature review assisted in exercising rational reflection and interpretation of the topic – to answer the question of why perceptions about and stigmatization of condoms exist.

1.4.3 Normative task: What ought to be going on?

The Normative task anticipates what ought to be going on with regards to perceptions about condoms. For instance what would God's will be for condom usage as preventative for contracting the infection; how should condoms, stigma and HIV and AIDS be understood?

Still following a hermeneutical literature investigative paradigm, the Bible as Normative source is investigated for answers to the present question (Osmer 2013: 7). By engaging in ethical reflection on what was discovered in the Interpretive task, the Normative task explores episodes, situations, and contexts with theological concepts.

It can be preliminarily indicated that the perceptions and beliefs about condoms /usage stem from an unhealthy view of sexuality. Ample usage was made of Louw's (2008) theory to assist in evaluating/understanding human sexuality and the human body where Louw formulates an integrative Christian spiritual approach to the sacred space of sexuality.

Kennedy's formulation of healthy and neurotic sexuality assisted in interpreting present concepts about sex and sexuality to derive norms for good practice. Within the Normative task sexuality cannot be separated from marriage, therefore Louw's theory on marriage and sexuality, discussing the growth of marriage and the 'we-space' of a relationship in order to comprehend the purpose of marriage and the purpose of sexuality in a we-space, had to be brought in. In answering the question of what ought to be going on, the Normative task assisted in developing ethical principles to channel situations, contexts and episodes toward moral ends.

1.4.4 Pragmatic task: How might we respond?

After the relevant dynamics of stigmatization were investigated, the Pragmatic task of how we might respond to the perceptions, attitudes and beliefs surrounding condoms comes to the fore. Exploring the Pragmatic task, different approaches as well as certain practical theological interpretations to answer the question above were considered (Osmer, 2008: 4-5). Certain practical conclusions and recommendations were formulated with a pastoral counselling view.

These approaches could assist a move towards de-stigmatization. Inter alia it includes discussion on relevant HIV education and awareness programmes, Pastoral Care and Counselling Methods and Programmes for people living with HIV and AIDS. A Pastoral Approach with Jesus as a model for Pastoral Counselling involves the paradigm shift from exploring the theology of the resurrection state to a theological critique on stigmatization. It becomes clear that the inquiry and exploration of different theories and texts provides a hermeneutical structural framework of enquiry. The objective then

is to find the best approach to de-stigmatize condoms and HIV and AIDS related stigma.

1.4.5 Data gathering methods

1.4.5.1 Literature review

To attend to the first research question (what is going on regarding the impact of perceptions and possible stigma have on condom use), the aim is to look at the perceptions people have about the different HIV and AIDS prevention interventions. The relevance of cultural and religious influence on these perceptions is important, particularly focusing on the discourses that culture and religion communicate. Insight into these perceptions and the cultural-religious influences was obtained by means of an initial literature review.

After relevant information about the impact of perceptions about condoms were explored thoroughly in the literature review, the information therein needed to be attended to in a more formal, objective manner. An Empirical component was included in the research's epistemological endeavour. The aim of the empirical study was to supplement the explorations surrounding perceptions of condom use from a quantitative and objective point of view. The empirical component to the research enables a deeper understanding of the perceptions held about condom use. Osmer's methodology was therefore ideal for this research structure, as his methodology allows for an empirical component under the descriptive task to assist with answering the research question; what is going on? Osmer explains that the empirical dimension of the descriptive task permits a more formal enquiry into the topic of the research and deepens the understanding of what is going on in the particular episodes, situations, and contexts (Osmer, 2008: 39).

1.4.5.2 Empirical data collection

The empirical study was drawn from the educated medical staff from a private Western Cape hospital. This particular sample group was chosen with the assumption that the sample will be drawn from individuals who have been educated on the topic of HIV and AIDS and have sound knowledge about HIV and AIDS and prevention thereof. In a country like South Africa, which is located in Sub-Saharan Africa (an area with known high HIV and AIDS prevalence rates) it can be assumed that educated medical staff members possess educated medical knowledge on the phenomenon (Van Dyk, 2012:

17). However, a possible limit to the research can be identified here; if educated medical staff, who had access to educational resources hold strong beliefs, attitudes and perceptions about condoms, could it then be said that the uneducated poor, with less access to educational resources might have even stronger held beliefs, attitudes and perceptions about condom use? This leaves open a space for further enquiry and a possible hypothesis for future research. Nonetheless, the exploration of the attitudes and beliefs of educated medical staff does assist to deepen the understanding of what is going on with regards to the perceptions educated medical personal have about HIV and AIDS and condom use and therefore has substantial relevance to this research.

In drawing up the sample, the human resources department of the private Western Cape hospital granted permission (*See Addendum C) to use a scheduled workshop and training session to ask voluntary participants (educated medical staff members). The participants were asked to complete and sign an informed consent, should they be willing to partake, and complete an empirical questionnaire, drawn up by the researcher, that explored the different attitudinal stances that the educated medical staff might have about condom use and HIV and AIDS, their willingness to use a condom and their demographic criteria (such as their age, gender, socioeconomic status etc.). The data was correlated statistically and reported. This data will be made available in Chapter Three of this research project.

The ethical clearance application for this research study was approved by the Research Ethics Committee: Human Research (Humanities) (See addendum D).

1.4.5.3 The Empirical Questionnaire

See Addendum A1 and A2

In the empirical questionnaire that the researcher formulated, a multiple choice structure was used to gather attitudinal and demographic data from the voluntary research participants.

Participants in the sample were asked to voluntarily complete the questionnaire through circling the answer that best suited their factual demographics and the answer that best suited their attitudes towards condom use.

The questionnaire consisted of different sections; the first section was a paragraph accurately describing the purpose of the study and the instructions on how to complete the questionnaire. The paragraph also explained that the information would be subject to both confidentiality and anonymity and that the participants were free to withdraw from the study at any point. This paragraph also stated the time the questionnaire would take to complete and that there was an informed consent that the participants had to complete in addition to the empirical questionnaire.

The second part of the questionnaire held questions of a demographic nature; investigating the demographic criteria of the participants, such as gender, race, age, socioeconomic status et cetera. The measuring of the demographic criteria was included in order to draw some relevance to the influence that cultural and religious affiliations might have on the attitudes and views people have about condoms. The attitudes measured made clear distinctions between condom use and condom non-use; thus, also exploring the willingness of the participants to use condoms. The reasons why both the demographic criteria and attitudinal stances were to be measured in the empirical questionnaire, was to assist in determining whether there was any possible correlation between the demographic criteria and the attitudinal stances the participants selected.

Finally, the third section of the questionnaire held attitudinal questions which investigated the willingness or unwillingness of the participants to use a condom, as well as possible attitudes influencing these.

Both English and Afrikaans questionnaires were made available to the participants. No other language translations were made available to the voluntary participants.

1.4.5.4 The Informed Consent

*See Addendum B1 and B2

Before the questionnaire could be completed, it was also required of the voluntary participants to complete an informed consent from. The consent form acted as an informative tool to participants about the nature, the purpose, the ethical implications (such as confidentiality and anonymity) and relevance of the study. Potential participants were provided with clear and detailed, factual information about the study, its methods, its risks and benefits, along with assurances of the voluntary nature of their participation and the freedom to refuse or withdraw without any consequences or penalties. Both are

clearly stipulated in the informed consent (eds. Terre'Blanche, Durrheim & Painter, 2006: 72-73). A signed consent was required for participation.

To ensure confidentiality and anonymity, the survey and informed consent form was collected alternately after completion. The data of the informed consent and the questionnaire will be monitored and handled by the researcher and the research team (the statistical analysts and research supervisors) only. No empirical questionnaire was allowed to be submitted to the data of the study without the supporting signed informed consent.

Statistical Analysis and interpretation was done after all the data was collected. Histograms were drawn up to interpret the data collected. During the Data Analysis and Interpretation the study will draw conclusions from the correlated data to objectively identify whether or not educated medical staff stigmatizes condoms and what attitudes and beliefs influence their willingness to use condoms. The Research will report the findings of the data analysis and interpretation in Chapter Three. This will conclude the Descriptive-Empirical task. The next task is an Interpretive task.

This task seeks reasons for the phenomena the study investigated in the Descriptive-Empirical task. If the pastoral problem is considered; the Descriptive-Empirical task explores the question; what is going on with regards to perceptions surrounding condom use. The Interpretive task aims to answer the question; why is it going on? With relevance to this research; why do the perceptions around condoms exist, and what are the factors involved in this regard? The Interpretive task is initiated with a Hermeneutical Literature Review in order to investigate what issues are embedded within the findings observed in the Descriptive-Empirical task; deriving some insight from the observed patterns of nature and human life.

1.5 HERMENEUTICAL LITERATURE REVIEW

After the conducting of both a small literature review and a short supportive empirical survey, the study is able to identify what is going on with regards to the perceptions people have about condoms. Under the Hermeneutical Literature review, the study will attempt to investigate three research questions and thus three of the tasks Osmer formulates, namely; the Interpretive task (why is it going on?), the Normative task (what ought to be going on?) and the practical task to conclude the research (how might we

respond?) (Osmer 2008: 4-5). This investigation takes the form of a hermeneutical literature review, as it explores and interprets texts and theories relative to the *meaning* of condoms, HIV and AIDS, stigmatization and sex and sexuality and functions as a structural guideline of enquiry into these.

1.6 HYPOTHESES

Practical Theology begins with episodes, situations and contexts that call for interpretation (Osmer, 2008: 12). It invites practical theologians to interpret the texts of the lives and practices of humanity as a "…living human document" (2008: 12).

From what had been investigated and subsequently observed in the Descriptive-Empirical task (Osmer, 2008: 4-5 – see Chapter Two, page 43), a *first* hypothesis may be suggested: stigmatization plays a dominant role in the perceptions, attitudes, and beliefs that people have about condoms. *Secondly*, the stigmas associated with HIV and AIDS are directly and intricately linked to stigmas around condoms and their usage. Consequently, the "living human document" that is scrutinised and interpreted in this study is the stigmatization of condom use, particularly amongst educated medical staff (Osmer, 2008:18-22). The research hypothesis is that education is not necessarily effective in moving towards de-stigmatized thinking of HIV and AIDS. Furthermore, the research proposes that knowing about HIV and AIDS does not necessarily motivate condom use to prevent the transmission of the HI-Virus (Taylor, 2009: 47). Within the context of the terrible reality and the almost insurmountable magnitude of the HIV and AIDS epidemic in the country, this stigmatization is a perplexing phenomenon.

The research will conjunctively explore the attitudes and beliefs of medically educated staff to comprehend the perceptions surrounding condoms for people who have informed knowledge of condom's preventative benefits – such as educated medical staff. It could, preliminarily, be envisaged that the findings of the empirical research in this study would prove that educated knowledge about HIV and AIDS does not necessarily motivate someone to use a condom; for such, the numerous variables such as attitudes, beliefs and opinions that outweigh than knowledge when it comes to decision making about safer sexual prevention options. One could ask here, why *educated medical staff,* and not an uneducated sample group? Perhaps this question opens ground for future enquiry. The hypothesis could be formulated that if one identified strongly held stigma-

tized beliefs, attitudes and perception amongst educated medical staff who have access to educational resources about condom use HIV and AIDS, one could hypothesize that the stronger held stigmatized beliefs, attitudes and perceptions might exist amongst an uneducated group. Furthermore, if it is determined that educated medical staff does not use condoms because of these strongly held stigmatized perceptions, one could hypothesise that their uneducated counterparts are even less likely to engage in condom use. This brings forth the final hypothesis; as one expects that stigmatised beliefs, attitudes and opinions about condoms influence people's inclination to, or not to use condoms and/or motivate and cause them to advise/warn others against such usage.

CHAPTER TWO

THE DESCRIPTIVE-EMPIRICAL TASK: THE ROLE OF PERCEPTIONS AND CULTURE ON THE HIV AND AIDS DISCOURSES ON CONDOM USE

2.1. INTRODUCTION

The Descriptive-Empirical task starts off by exploring what is going on with regards to the perceptions surrounding condom use. More specifically, the study plans to explore the impact perceptions have on condom use.

It is well known that the HIV and AIDS phenomenon is considerably influenced by stigma, discrimination and ignorance. To comprehend what is going in with regards to the HIV and AIDS phenomenon it is a requirement to investigate the extent of the stigma surrounding HIV and AIDS. Furthermore, the study needs to look at educational interventions for HIV and AIDS and ascertain if they are truly informative and able to contest the ignorance surrounding HIV and AIDS.

The purpose of this study is to investigate whether condom use as preventative measure is in fact being stigmatized. Moreover, the study aims to explore whether the stigmatization of condoms is impacting on the HIV and AIDS phenomenon.

In the Descriptive-Empirical task the study initiates this exploration through the use of a literature review with which the study hopes to answer a few questions, namely; are condoms being stigmatized? Should the study find that condoms are being stigmatized, is it a result of the stigma's surrounding HIV and AIDS or is it fuelling the stigma surrounding HIV and AIDS? Can the study conclude that stigma associated with HIV and AIDS and the use of condoms are a result of poor education? Or can it be ascribed to ignorance? Moreover, is this ignorance grounded in the beliefs and attitudes people hold? These research questions will guide the research in the initial literature review, and first part of the Descriptive-Empirical task, to determine what is going on with regards to the impact of perceptions about condoms.

In this chapter, the study starts the investigation by giving an overview of the different prevention strategies possibly influencing the belief and attitudes people hold. To en-

lighten the notions regarding the impact perceptions have, the study needs to explore the related prevention interventions that communicate safer sex[1] practices on multiple levels; with relevance to this research, the study will place particular focus on condom use. In this chapter the study will also be looking at the relevance and impact of culture and religion on perceptions of prevention interventions. The study will also investigate the existing discourses surrounding HIV and AIDS and the impact thereof.

2.2 OVERVIEW ON PREVENTION

There are several strategies that can be used with regard to prevention; which can be implemented on an individual, behavioural level or on social and group focused levels. Things like testing blood for blood transfusions, the prevention of mother to child transmission (pMTCT), the treatment of sexually transmitted infections (STI's), and promotion of lifestyle change concerning safer sexual behaviours - such as condom use - are commonly known interventions strategies that have been administered in the past (ed. Visser, 2007: 192).

Programmes that focus on individual and behaviour modification aim to reduce high-risk behaviours such as; drug and alcohol abuse, earlier onset of sexual debut, and unprotected sexual activity (ed. Visser, 2007: 193). However, results show that individually focused programmes are limited; as a large portion of individuals do not protect themselves sexually, regardless of their knowledge of the risks pertaining to unprotected sex. Condom distribution programmes and information on how to use condoms are considered one of the means to reduce high-risk sexual behaviour (ed. Visser, 2007: 192). However, the knowledge about the risks is not enough to influence the individual decisions towards a healthy lifestyle (ed. Visser, 2007: 193). Joubert-Wallis and Fourie (2009: 107) state that "Behaviour that sprouts from cultural beliefs and traditions is thus important to individuals in the community as well as the community as a whole and can therefore not simply be changed by education or knowledge about HIV or other health issues".

[1] UNAIDS prefers the term *safer sex* practices. The term *safer sex* implies complete safety. The term safer sex more accurately reflects the idea that choices can be made and behaviours can be adopted in order to reduce even minimum risk. Under these circumstances individuals chose the reduction of the number of sexual partners and correctly and consistently use condoms to reduce their risk of HIV transmission. In contradiction, *safe sex* refers to 100% safety from HIV transmission; where both partners, in a serial monogamous relationship, know their zero status and neither partner is in the window period (Louw, 2008: 459).

Individual skills and knowledge training fail to address the socio-cultural context relevant to safer sexual practices. Factors such as, the social setting, peer group norms, and partners refusing to use condoms contribute to the behaviour and decisions of the individual; ultimately fuelling the stigmatization of condoms. Moreover, programmes focusing on group norms and social processes need to be implemented in accordance with individual focuses; consequently, multileveled intervention programmes (ed. Visser, 2007: 193).

Fundamentally, individual sexual behaviour is shaped by cultural beliefs and the social contexts surrounding meanings attached to relationships, protective measures (condom use) and gender roles. Change involves collective action and the participation of members in communities (ed. Visser, 2007: 193). Community based interventions involve peer education; participative action where information can be exchanged and important issues can be discussed amongst peers. The use of group leaders as models for desired behaviour has also become a popular and somewhat effective strategy for community based interventions (ed. Visser, 2007: 193).

On a community level, certain demographic criterion proves to have substantial and fundamental influence on the transmission of the virus. Research shows that HIV and AIDS flourish in areas where high levels of unemployment, homelessness and illiteracy, welfare dependency and criminal activity prevails. It is therefore safe to say that HIV and AIDS is directly related to social issues such as poverty, overcrowding, lack of health care services and lack of recreational facilities (ed. Visser, 2007, 191). As seen in Visser, Schoub identifies three issues that needs to be addressed on community level to address the HIV and AIDS epidemic society is faced with in the South African context, namely; (a) poverty and overcrowding, (b) the economic dependency of women – which causes many difficulties with regards to disempowerment of women in sex and sexuality, and lastly, (c) migratory labour associated with single-sex hostels (ed. 2007: 191). According to Lindegger and Wood, the HI-virus has taken on the stature of a social barometer which highlights both the social and economic imbalances in societies and between countries and national economies (1995: 7).

When implementing community based programmes to combat the spread of HIV through the implementation of these programmes on numerous levels, community workers generally consider risk factors that need to be addressed, namely; (1) the per-

ception of one's personal vulnerability, (2) negative attitudes towards condom use (stigmatized notions of condom use), (3) the impact of group norms and cultural beliefs, (4) gender inequality, (5) and socioeconomic status related to power relations (ed. Visser, 2007: 192). The deduction can then be made that the abovementioned five factors contribute to people's consideration of safer sex practices. These five factors are explored in the empirical study later in this research (see Chapter Three).

Furthermore, preventative measures that address HIV and AIDS related sexual behaviours also need to account for the dynamics of human sexuality[2]. The knowledge of how to practice safe sex and having the belief that one is capable of doing so does not necessarily translate into behaviour modification for safer sex practices (Taylor, 2009: 378). Attitudes, as well as perceptions[3] in a culture on human sexuality and towards condom use play a fundamental role in the implementation of this safer sex practice; as more favourable attitudes and particularly those who perceived subjective norms to be more supportive of condom use reported greater intentions to use condoms (Taylor, 2009: 378). In careful consideration of the abovementioned; the beliefs and perceptions cultures and social groups hold about condoms arguably influences this particular safer sex practice tremendously.

Why is condom use considered as preventative intervention? Condoms, as community intervention, have been promoted as and are considered a safe sexual practice which significantly reduces risk of body fluids being exchanged. A condom acts as a barrier between body fluids. Moreover, this protects individuals from contracting both HIV and other STI's (Sexually transmitted infections) and also acts as a contraceptive[4]. It is important for condoms to be used consistently and correctly in order for it to be effective and for individuals to gain the benefits thereof. When used correctly and consistently, research proves condoms to be 80-95% effective in the prevention of HIV transmission (Brown, Duby, Schiebe and Sanders, 2011: 74). Therefore, it is argued that

[2] Sexuality is part and parcel of our being human and functions as an expression of our human intimacy. Sexuality is furthermore intrinsically connected to the soul; as it is the ensoulment of the body and the embodiment of the soul. It becomes a spiritual issue, as it expresses one's innermost being. Human sexuality becomes dysfunctional when it becomes a defence against loneliness and fear of rejection. It becomes "sick" when it becomes a means to an end (Louw, 2008: 353).

[3] The 20th Century will be marked by the debate on the meaning of sexuality, gender issues and the stance of the church on the human sexuality. The debate is shifting from a pessimistic stance towards sexuality to a liberated, free, individualised paradigm (Louw, 2008: 352).

[4] Contraceptive practices are often viewed by young African people as a cause for infertility and venereal diseases. It has often also been seen as the plot of white people to limit the black population grown and fundamentally black political power. Of all forms of contraceptives, condoms are the most unpopular as they are considered a barrier to physical contact (Louw, 2008: 459).

condoms should be used when having vaginal, anal, and oral sex (eds. Chalcraft, Leech, Mead & Mokgethi-Heath, 2011: 3). Problematically, condoms are not being used consistently or correctly. Speculatively, this could be ascribed to the stigmatization of condom use due to cultural connotations and beliefs people hold about sexual practices. Sex with a condom is often considered to be shameful in some contexts (eds. Chalcraft *et al*, 2011: 3). This is but one of the cultural influences affecting the consistent use of condoms and safe sexual practices. The focus on condoms use in particular might help one gain insight into people's perceptions about condoms in particular as the above indicates that condoms are not as well received in society as some other preventative HIV and AIDS interventions might be. The question is then whether this too can be ascribed to the connotations and beliefs people hold about sexual practices.

It is argued that individuals make limited choices when functioning in their environment. Moreover, this functioning is affected by political, economic and legal structures, which constitute the norms and institutions within societies. Therefore, as briefly mentioned above, efforts that attempt to modify the sexual behaviour of individuals need to consider that these behaviours are rooted within and sustained through constant interaction and on-going relationships within the individuals' social environment (Joubert-Wallis & Fourie; 2009: 105). One could therefore argue that people's actions are not free form societal influence, as one behaves in manners which make sense within certain social contexts – manners that one has learned from their social contexts to be acceptable or applicable. Their attitudes and choices are irrevocably influenced by the cultural norms that one observes (Joubert-Wallis & Fourie; 2009: 105). Ultimately, cultural meanings attached to sexuality, reproductively and relationships have a fundamental influence on behaviour patterns (ed. Visser, 2007: 191).

According to Joubert-Wallis and Fourie, the course of the HIV epidemic is influenced by factors such as people's expression of sexuality, drug and alcohol use, the media, the responses of the government, as well as the public's discernment of the seriousness of the disease (2009: 106). It can then be argued that the seriousness of the epidemic should lead to the re-examination of people's social systems, their beliefs, behaviours and institutions; the understanding of any construct can be linked to people's culture (Joubert-Wallis & Fourie, 2009: 106).

In this chapter the study will be exploring the different perceptions about condom use with relevance to the preventative interventions being communicated to society and general educational and awareness campaigns. The possible beliefs and attitudes impacting on stigmatization of HIV and AIDS will be explored, as well as further exploration on whether there are stigmatized perceptions about condom use, by looking at the relevance of culture and religion on perceptions and the difference between culture and religions, contextually. Furthermore, the study will be exploring the cultural dynamics of the influence of gender dynamics and dynamics of poverty on these perceptions surrounding HIV and AIDS and condom use. To conclude the chapter, the study will investigate how different discourses impact on perceptions of condoms and HIV and AIDS. Three frameworks of discourse will be explored to further comprehend the perceptual reference the research seeks to identify.

2.3 RELEVANCE OF CULTURE ON PERCEPTIONS

After considering the above, the questions the study is faced with are: What is culture? How and why is it influencing the course of the epidemic to such a large extent? How is culture relevant to condom use in particular?

According to Louw (2008:153), the word culture comes from the Latin word '*colo'* which means to nurse the earth through a plough in order to live. Joubert-Wallis and Fourie (2009:106) indicate that the term *culture* is from the Latin word '*cultura'*, which means to cultivate. In accordance to the understanding projected by Louw, it is used in reference to patterns of human activity and structures that ascribe significance and meaning to these activities (Joubert-Wallis & Fourie: 2009: 106). Culture can also be understood as the way of life for societies. "Culture includes certain codes of conduct, norms of behaviour (e.g. law and morality), dress, language, *religion*, system of belief and rituals, and is visible in a society's music, literature, painting, sculptures, theatre, and so on" (Joubert-Wallis & Fourie: 2009: 107). Although the term 'culture' has many uses, Hook states it as follows:

> …knowledge that is passed on from one generation to another within a given society, through which people make sense of themselves and the world. It incorporates language, values, assumptions, norms of behaviour, ideas about illness and health, etc. (Hook, 2004: 34).

According to Louw, culture, within an African paradigm, proposes that human beings cannot be understood in separation from their cultural issues and values (2008, 153). He further states that humans are inextricably embedded in culture as culture is an expression of the creative and ingenious human spirit; therefore culture is a sacred endeavour (Louw, 2008: 153). In support of Louw's pronunciation, Hopkins states:

Culture is where the sacred reveals itself. As a result, one only knows what she or he is created to be and called to do through the human created realm of culture (2005: 83).

Ultimately, culture can be understood as the human attempt to re-create creation through (a) spiritual-religious enunciation, (b) ethically drives such as norms and values, (c) aesthetic imagination such as art, (d) technical inter- and invention, language and speech and social and political restructuring; all in an attempt to move towards a humane environment (Louw, 2008: 153).

In support of these statements, various empirical studies found that culture plays a formidable role in human decision making. Even though individual factors (e.g. knowledge and confidence) play a role in sexual behaviour and ultimately the spread of HIV; these factors are influenced by a person's social context (a person's culture) (Joubert-Wallis & Fourie: 2009: 107). It is safe to deduct here that individuals have limited freedom when it comes to decision making as in numerous cultures; decisions are profoundly influenced by the social and cultural context (Joubert-Wallis & Fourie: 2009: 107). Behaviour that sprouts from cultural beliefs and traditions is thus of significance to persons within a community setting, as well as the community as a whole. Ultimately, behaviour cannot simply be altered through education and knowledge about HIV.

One becomes obligated to explore this line of thinking further by asking; what are the factors that impact on the social contexts and culture and therefore impacting the perceptions of HIV and AIDS and possibly even condom use. In other words, explore in more depth what dynamics play a role in the social and cultural contexts and spill over into personal belief. The first point of departure in this exploration is an investigation into the dynamics of power in society. Under this dynamics of power and dynamics of poverty will be explored in depth

2.3.1 Dynamics of Power

HIV and AIDS flourishes in marginalised social groups. Amongst these marginalised social groups are those with the least access to economic power, political power and symbolic power (access to respect and recognition) (Joubert-Wallis & Fourie, 2009: 112). People in positions of little or no power often do not have the freedom to contribute or participate in decision making activities and it is unlikely that these individuals will ever influence to promote the development of health enabling environments. Particular emphasis can therefore be placed on unequal power dynamics relative to HIV and AIDS, as the spread of HIV and AIDS is both enabled and constrained by social contexts communities function in. That said, one can question the power dynamics relating to gender inequality, as well as power relations between the rich and poor. What are the dynamics between rich and poor and what are the dynamics of gender inequality, and how do they impact on HIV and AIDS? Is there a correlation between the two and how do these dynamics impact on the perceptions of condom use?

In a patriarchal society like Sub-Saharan Africa, one identifies that gender plays a large role when one talks about power dynamics (Joubert-Wallis & Fourie, 2009: 112). The question can be formulated; what are the power dynamics between genders and how are these dynamics impacting on the perceptions surrounding HIV and AIDS and condom use?

2.3.1.1 Gender Dynamics

Gender is often accepted to be a social construct differing from the construction of sex, pertaining to biological status. Jones states that gender refers to the socially constructed systems of meaning that identify various perspectives according to the binary distinctions of male and female (2000: 8). When expressed in sexuality, gender takes on an extensive range of physical and psychological stances particularly in terms of behavioural and attitudinal variables (Bird, 1997: 172). A person's sex can indeed be determined biologically, but the meaning, purpose and role functions are grounded in the social and cultural systems of meaning (Louw, 2008: 380).

The core of the gender debate resides in the meaning of being human as either male or female in gender. Because of cultural images of distinction maleness and femaleness are determined by perceptions of masculinity and femininity. Specific gender role func-

tions stem from these and lead to typologies pertaining to maleness and femaleness: projection and reinforcement of stereotypes (Louw, 2008: 383). Gender issues arise from stereotypes and the media has an intricate role to play with regards to projections of stereotypes and communication of typologies. However, the most determining factors in masculinity and femininity are the dominating cultural philosophical paradigms people live by. These paradigms determine perceptions regarding male and female behaviour and in effect these perceptions are embodied in gender role functions. The perceptions have a prescriptive function, as they impose the expression of masculinity and femininity (Louw, 2008: 384).

In the cultural philosophical paradigm of patriarchy, males are viewed in a light of superiority, as men are seen as dominant in the family and leaders thereof. Males are in charge of making important decisions regarding the family and women have to accept these decisions. Males are viewed as more intelligent and therefore superior to women (Joubert-Wallis & Fourie, 2009: 113). The role and hierarchical place of a woman in some cultures make them more vulnerable for HIV transmission as power dynamics between men and women are fundamentally prevalent in sexual relationships and decision making too. The discourse of power in terms of gender inequality ultimately influences the practice of safe sex and negotiation of safe sex and condom use (Collins, 2003: 23-41). Males are most commonly seen as more powerful and have the 'right' to decide what happens in the relationship; I.e. make decisions surrounding condom use or non-use. From such a position of power, males might place themselves and their partners at risk by engaging in promiscuous behaviour and refusal to use a condom (Joubert-Wallis & Fourie, 2009: 113).

There are multiple contributing factors that assist in the constitution and affirmation of men's position of power, these include; female employment rates, female education levels as well as fewer and less paid employment opportunities to move towards economic freedom. This state of being reinforces a position of female's dependence on men and enforces tolerant behaviour (Joubert-Wallis & Fourie, 2009: 113). Socially constructed notions of masculinity can also be considered here, as the ideas that men cannot help but have multiple sexual partners due to uncontrollable sex drives become formidable. Moreover, the notion that manhood is affirmed only when men have many children and therefore claim a right to not use condoms also becomes relevant under the discourses of masculinity (Collins, 2003: 23-41).

In general, women are seen as objects of men's desires, resulting in men viewing women's sexual behaviour in accordance with men's sexual needs and urges. 'Condomless' sex is, under multiples cultural discourses, viewed as more pleasurable and more 'real'. Condoms are also often interpreted as a sign of infidelity or as an indication of an HIV positive status; as the person requesting the use of the condom is assumed to be infected (Joubert-Wallis & Fourie, 2009: 114). Research indicated that even when women believe they have the right to say 'no' to a man with regard to sexual behaviour, they seldom act on this belief because of the inequality in social position that exists. This proves that negotiation of safer sex is problematic for women; as 'un-equals cannot negotiate' (Baylies & Bujra, 2000: xii).

Many different structures and dynamics of male power relations exist in different cultures. In other words, not all cultures and societies have a patriarchal social system. Some cultures have equal power relations and other cultures might even have a matriarchal dynamic system. It is for this reason that cultural and social discourses surrounding masculinity and femininity in the realm of gender dynamics should also be considered relevant in relation to the HIV and AIDS epidemic.

As mentioned, the gender dynamics affirming men's position of power is also an economic one, due to higher female unemployment rates and education of females resulting in less economic freedom for females and ultimately the economic dependence of women on men (Joubert-Wallis & Fourie, 2009: 113). What are the other dynamics of economic influence in terms of power dynamics and how are these relative to HIV and AIDS and condom use? Through exploration of the power dynamics of poverty, one might be able to gain insight on how poverty impacts the perception and stigmatization of HIV and AIDS and possibly even the perceptions of condom use.

2.3.1.2 Dynamics of Poverty

Socio-economic power brings forth a difference in power, particularly in terms of economic resources and opportunities. Numerous health-related behaviours are linked to unequal distribution of political and economic power. Impoverished people often lack adequate food and shelter as well as good education and access to healthcare, which places these people in a vulnerable position with regards to illness and economic displacement (Joubert-Wallis & Fourie, 2008: 115).

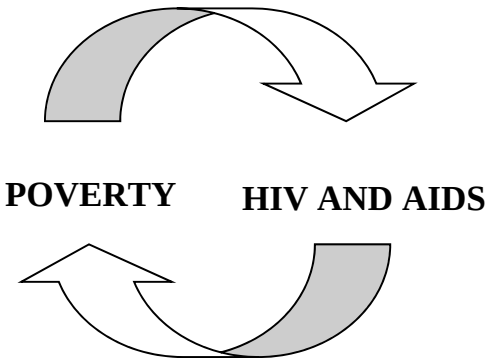
What are the dynamics involved between HIV and poverty? Is there and interplay? If so, how do HIV and AIDS cause poverty? And how does poverty cause HIV and AIDS?

According to Magezi; "Poverty is likely to top the list of factors that cause HIV and AIDS in Africa" (2007:49). It has been identified that HIV and AIDS prevalence rates are higher in poorer African countries than in the wealthier European countries. Moreover, the trend is evident in South Africa that poorer people are affected more by HIV and AIDS. The question is then; what is the nature of the interplay between HIV and poverty? (Magezi, 2007: 49).

Poverty increases vulnerability to HIV infection which, in turn, places the family into a position of greater poverty. HIV therefore exacerbates poverty as the breadwinner falls in and becomes powerless and unable to work (Magezi, 2007: 50). Regardless of this simple deduction, the relationship between HIV and poverty is not so straightforward. In the following diagram (Figure 2.1), one is able to depict how the interplay between these two factors functions dynamically:

Figure 2.1: Poverty and HIV and AIDS interplay: (Magezi, 2007:51)

- Increased vulnerability to high-risk situations
- Lack of access to information and education in terms of prevention
- Lack of access to healthcare services
- Less control over life choices.



- Loss of income or work
- Increased health costs
- Funeral costs
- Increased dependency ratios
- Lower productivity at work
- Reductions in national income

Poverty causing HIV and AIDS, as listed in the diagram above, include a few factors that can be explored. Firstly, the one of the main dynamics is the increase vulnerability to more high-risk behaviours and situations. Homelessness[5] and migration are one of the two main contributing factors as these situations leave people with little choice but to participate in high risk situations (Magezi, 2007: 51).

People in impoverished, homeless positions argue that one might die from hunger before one dies from AIDS. For these, a plate of food is more valuable than anything; rendering the worry of HIV as much less important. People who suffer from homelessness and live in informal settlements often sell sex for money as a means of survival (Magezi, 2007: 52). Migrant workers are also of concern here; as poverty forces people to migrate to cities and places where work is available. This often involves moving away from their families and wives for long periods of time. Labourers are often not skilled or educated enough for the work and are subjected to low wages, poor conditions in hostels (mining hostels) and no privacy in conjunction (Magezi, 2007: 52). Many migrant workers argue that sex with sex workers becomes the only female company and relief they have from their difficult situations; cumulatively contributing to the transmission of HIV.

HIV and AIDS awareness media programmes often do not reach all people, due to the fact that everyone does not have access to media resources (television and radio). Rather ironically, the information communicated through these chains does not reach the communities in need of the information. Mass media campaigns should take note of this in future development of programmes. Whiteside and Sunter states that poverty and lack of information are intricately linked (2000: 20).

Impaired access to medical services and resources to the poor has further implications for the transmission of the HI-virus. Untreated medical conditions, particularly STI's (Sexually transmitted infections) increase the likelihood of HIV transmission considerably. Lack of funds to buy medication and access to treatment all function under the power dynamics of poverty and its influence on HIV (Magezi, 2007: 53). However, low income in itself is not the only reason for less utilization of medical services; there are few medical services available to the poor. The services made available are often inad-

[5] 'Homeless' generally refers to not having a roof over one's head. However, in the African context, homelessness as a concept should be extended to people who live in informal settlements; as they live in temporary housing and are associated with as many high-risk situations and activities.

equate and understaffed; therefore, medical services are used by the poor on mainly an emergency basis.

The biggest gap between the rich and the poor is prevalent in the use of preventative health services, which lay the groundwork for poorer health across a lifetime (Taylor, 2009: 206-207). Even though distribution of condoms as a preventative health measure is being done by NGO's and clinics, the correct use of condoms and benefits of condom use is not being projected in the correct context sensitive conducts, and little of the preventative services made available are being utilized. This might be a result of stigmatized beliefs, as one might not want to be seen at a clinic seeking information on HIV and AIDS or Condoms – as people might think that one is promiscuous or even HIV positive. Many people living in poverty do not have access to transport to get them to medical assistance, and often poor, rural people live long distances away from the closest medical service.

The dynamics of power in the context of poverty is also intricately linked to gender inequality. The power relationship between the rich and poor often becomes a power relationship between men and women as men are more likely to be employed and have higher levels of education (Joubert-Wallis & Fourie, 2009: 115). Gender inequality dynamics have been explored above, however; the economic disempowered position exacerbates the power dynamics involved in gender inequality. Women make up most of the poor economic strata; as 60 percent of female headed household live in poverty. Men show their 'power' by engaging sexually with multiple partners and women exchange sex or engage in sexual relationships in order to gain economic support from men. Men also use their money to buy alcohol and drug as a means of manifesting their power in society (Joubert-Wallis & Fourie, 2009: 115). Ultimately, women are being exploited due to their social and economic positions. These exploitive tendencies are even higher in women who are uneducated and have and impoverished social standing (Magezi, 2007: 54). Van Dyk formulates that the risk of transmission in women is two to four times higher for women (2002: 209ff).

Lack of control over life choices are often misinterpreted and left unexplained in statistics, especially when regarded in terms of sexuality. The NMH report in 2002 revealed the following prevalence rates of HIV and AIDS between men and women (NMH, 2002: 2).

Diagram 2.1: HIV prevalence rates in men and women (2002):

Age Group:	**15-19**	**20-24**	**30-34**
Males	4%	8%	24%
Females	7%	17%	24%

As noted the numbers par as the ages increase. A possible explanation for this can be related to poverty. African men prefer to engage with younger females, as older men have the economic resources; therefore scouting for younger, more economically dependable women (15-19 and 20-24) (Magezi, 2007:55). Paying *labola* (bride price) is another factor, as men delay marriage in order to work for many years, until one is able to pay for a bride. This has two implications; men become involved in alternate sexual relationships during their marriage delay period and secondly, helpless young women are quarry for men as one is not in a bargaining position when it comes to sex (due to age gap, cultural values and economic privileges) (Magezi, 2007: 55). Moreover, these women are unable to negotiate the introduction of condoms into their sexual relationship. Poverty then comes into play in the sense that older men are the ones with economic stature and attract impoverished young women, thus reflecting the abovementioned.

It is safe to say that poverty has a substantial impact on HIV and AIDS prevalence and incidence rates. However, HIV and AIDS also exacerbate poverty by loss of income due to illness or death, high costs of treatment, funeral costs and increased dependant ratios and orphaned children. One must therefore conclude on this discussion that the nature of the interplay between HIV and AIDS and poverty works in two directions: poverty makes people more susceptible to HIV transmission and in turn, HIV fans the flames of poverty as the potential productive (breadwinner) becomes powerless economically and physically (Magezi, 2007: 65). In this deduction it must be noted that the interplay between HIV and AIDS and poverty should not be approached simplistically. One is encouraged to take on a contextual analysis to determine and explore specific factors responsible and relevant to the interplay between HIV and AIDS and poverty (Magezi, 2007: 65).

It is also found that the study needs further exploration of the cultural factors related to prevention measures and safe sex practices as gender inequality, power dynamics due

to poverty and perceptions towards safer sexual practice (condom use) is grounded in cultural discourse and contexts. Crucially, one must note here that culture in itself can and should not solely be blamed for the course and multitude of the HIV epidemic, but one is obligated to consider the complexity of culture as one of the contributing factors of the complicated HIV epidemic (Joubert-Wallis & Fourie: 2009: 107). Moreover, the recognition of cultural, ethical and gender differences also becomes a significant consideration in the process of understanding social thought and behaviour (Joubert-Wallis & Fourie: 2009: 107).

It would be safe to state here that HIV is considered a behavioural disease. Its link to human behaviour implies that the virus is often associated with morals, values and virtues (Louw, 2008: 424). This renders human behaviour as problematical, as decision making and responsibility take on new dynamic meaning.

If it is true that culture encompasses the complete life of people (morals, religious beliefs, social, political, economic and educational structures, and other products of their creative spirit), then it is safe to conclude that an exploration of culture should include the aesthetic, spiritual and sanctified dimensions relative to culture (Louw, 2008: 153). What is important, and particularly relevant from a practical theological point of view, is that religion, faith and spirituality cannot be understood without the understanding of culture. It is therefore obligatory to explain what is understood under religion and culture and investigate how they interact, as they are often seen as the same notion or even seen as products of each other. In the next section the research will look at culture and religion in relation to the HIV and AIDS phenomenon, with relevance to the discourses that flow from culture, both collectively and independently.

2.4 CULTURE AND RELIGION

The word culture is remarkably inclusive of many notions. This leads to the next position of questioning: Are culture and religion the same thing? How are they different? How should they be understood in relation to the research? How are the two alternate concepts relevant in the understanding of perceptions of condom use?

The body of the church is made up of the people in the church. The ecclesial view of humanity as the body of the church becomes blurred and confused if the body of the

church is made up of HIV positive individuals (Louw, 2008, 424). Is there room for HIV positive people in the community of believers?

Sexuality used to be a private affair; however, HIV has unmasked sexuality to demonstrate that sexuality is also a public and socio-cultural phenomenon. HIV exposes sexuality in terms of promiscuity, eroticism and irresponsible sexual behaviour and it becomes a disease grounded in morality and sexual morality. Thus, what people do in 'private', now affects the entire community. Human sexuality then becomes considered from a public and cultural context. This brings back the previous discussions; what are the cultural norms and values relevant to sexual behaviour? (Louw, 2008: 425). The exposition of sexuality though HIV should also be considered as a relevant factor when considering the stigmatization of condom use, as well as notions of sexual morality and sin with regard to human sexuality.

Before further engagement in discussion on cultural and religious factors that influence perceptions of condom use, one needs to consider the notions and distinctions between culture and religion in itself. These two entities are often used as synonym and the one is often used in conjunction or derivative of the other. For that reason it is necessary for use to draw a clear distinction between the two concepts.

Religion is found in some form in all human cultures and often carries countless definitions across fields of inquiry. The Christian faith is founded in the same religious text, but is religion, in different cultures, experienced in the same way? In some religions spiritual growth of the individual is the focus and in another culture the religious and spiritual grounds might be focused on the strength of the community; as seen in African cultures. It is then safe to say that religion has played a role in the development of culture, just as culture has acted as a frame by which religion has been made meaningful (Sasaki & Kim, 2011: 401).

Some of the dynamics of religion might include highly committed ritualized practices and beliefs shared within a community which is centred on the metaphysical or divine. In understanding religion it is commonly categorised as a specific from of culture or distinct cultural practice, however, religious beliefs and practices transpire with within national cultural contexts. Often the same religious teachings manifest religion in different manners across cultural contexts (Sasaki & Kim, 2011: 402). The question one is

faced with then is; how does culture shape individual psychological experiences and collective expressions of religion.

It can be acknowledged here that culture and religion overlap conceptually, but the two concepts are distinguishable: Religion can be conceptualised as form of culture because of its unified system of beliefs and practices that tends to vary across differing religious traditions. Notably, religion focuses on the relationships with the divine (Cohen, 2009: 194-204). This considered, when the distinction is characteristically drawn, religion can be understood as "an overarching system of beliefs and practices concerning the super-natural" and culture as "a meaning system in which psychological processes are con-figured differently across nations and, thus, as a context in which religion takes place" (Sasaki & Kim, 2011: 402).

It can then be said that culture influences and impacts on religion as much as religion influences and impacts culture, and the two are intricately linked. Different cultures hold different stances on social affiliation and secondary control with regards to reli-gion. For example, people in individualistic culture holds a more independent view of the self and place stronger emphasis on personal choice and personal relationship with God. In contrast, a community focused culture might hold a more interdependent view of the self and can be considered as spirituality more collectivistic in cultural practice. In the collectivist view, the self is inherently connected the other, such as the concept of *ubuntu* - being someone through the existence of the other (Sasaki & Kim, 2011: 402; Louw, 2008: 148). Both the individualist and collectivist cultural definitions mentioned follow the Christian Religious Doctrine. This explanation can be supported by a quali-tative study by Sasaki and Kim. In their study the research confirmed that the role of re-ligion differs depending on the culture. Their qualitative study also proved that one re-ligion may have varying impacts depending on the larger cultural context (Sasaki & Kim, 2011: 411).

It was noted in the qualitative literature study that the research focused on how culture shaped religion, yet it should not be discounted that religion has had previous impact on culture too (Sasaki & Kim, 2011: 411). Undeniably, religion has contributed to the formation of culture in the past and vice versa.

In this, it is safe to deduct that culture and religion cannot be separated, yet they are in-dependent. It was also determined that culture and religion have discourses that com-

municate certain perceptions about condoms and HIV and AIDS. Discourse is never neutral and needs to be explored in order to comprehend how perceptions about HIV and AIDS are being communicated. This exploration will further assist in answering the primary research question of what is going on with regards to perceptions about condom use.

2.5 HIV AND AIDS DISCOURSES

2.5.1 What is discourse?

Before the relevant discourses can be discussed in relation to HIV and AIDS, one must explore what a discourse is and how it can be understood here. Discourse is often incorrectly formulated as language; however, discourse can be referred to as a 'linguistic usage' or a 'language-event'. Ricoeur identifies four traits that distinguish discourse from language: Discourse is (a) *temporal* - a fleeting event realised in time – (b) it is *subjective* - it tends to have a speaker whose subjective intention determines the meaning of the discourse – it is also considered to be (c) *actualised* – as it refers to a world that it claims to describe, to express, or to represent – and lastly, discourse is addressed to someone and is therefore (d) an interlocutor (1991: 145-150). At least two of these traits (interlocutor and subjective) are relevant in the discussion of HIV and AIDS, and is of particular relevance when one considers Christian AIDS discourses.

Bové stated that it is crucial to know how discourse functions, understand where it is found, how it is produced and how it is regulated (1995: 54). He formulates that discourse is a tool with which one can describe the linkage between knowledge and power. Ultimately, discourses constitute truths and produce knowledge as opposed to discovering or transmitting it (Bové, 1995: 54).

There is, furthermore, an identified link between discourse and institutions and this becomes evident in the way the medical institutions were able to impose their biomedical and scientific understandings of HIV and AIDS as the 'gay cancer', considering that AIDS was initially called GRID (Gay Related Immune Deficiency). The communicated discourses of medical institutions often influence the medical research being done on HIV; determining which research receives funding (Schmid, 2006: 94-95). Evidently, power shapes discourse: This is evident in PEPFAR for example; the emphasis on pre-

vention by promotion of abstinence has resulted in devastating consequences for prevention programmes thus far (Schmid, 2006: 95).

It becomes clear that discourse is never neutral and one must therefore be aware whose agenda one is tapping into when discourses are under consideration – particularly discourses pertaining to HIV and AIDS.

2.5.2 How are Discourses Affecting HIV and AIDS?

When one considers the relevant discourses pertaining to HIV and AIDS, one becomes concerned with how HIV and AIDS discourse functions and how power is exercised through this discourse. One becomes obligated to focus one's attention to the people being oppressed by discourses of control and exclusion and consider how these people resist this oppression with discourses of human rights and empowerment (Schmid, 2006: 95).

Seidel (1993: 177) identified six conflicting AIDS discourses operating in the African context:

- The medical discourse: This is a dominant authoritative discourse that focuses its primary concern on the medical functions (symptoms, stages etc.) relevant to AIDS, resulting in a depersonalised discourse. It functions as a more sophisticated discourse of control and exclusion and constitutes understanding of the virus along a scientific paradigm. As a result this discourse disregards multiple other aspects relative to the HI-virus. Consequently, this discourse has led to the identification of risk groups (Men who have sex with men, injecting drug users, etc.); this identification has resulted in labelling and the inflation of stigmatization and the imaginative belief of some thinking they are not at risk (Seidel, 1993: 177). This discourse conflicts the African beliefs about illness and disease that conclude that disease is grounded in witchcraft or sorcery.
- The medico-moral discourse: Under this discourse, social categories of the medical discourse are adopted; in effect, within this discourse blame is passed onto risk groups and prevention is promoted through individual behaviour modification. Religious groups under this discourse view AIDS as God's punishment for human immorality. Ultimately this discourse involves the blaming of others and the stigmatization of people living and affected by the virus. The use of condoms as pre-

ventative measure is also rejected and this is justified by percentage failure rates for condom usage – this conviction is grounded in cultural or religious arguments (Seidel, 1993: 177).

- The development discourse: This discourse stresses the developmental link to AIDS and leads to a certain construction of women and gender. Furthermore, this discourse explores how socio-economic factors impact on sexual behaviour, ultimately assisting in the development of successful AIDS prevention programmes.
- The legal discourse: This discourse is underpinned by international human rights declarations. One of the aims of this discourse is the debunking of existing norms surrounding HIV and AIDS; thus, the safety and 'de'-marginalization of infected persons are stressed in the realm of human rights. Respect for human dignity and the right of people living with HIV and AIDS are regarded as essential for the development of effective HIV programmes (Seidel, 1993: 177).
- The ethical discourse: This discourse explores issue surrounding compulsory testing and disclosure. The discourse is grounded in a somewhat utilitarian perspective; focusing on the promotion of the greatest common good (Seidel, 1993: 97). The danger of this discourse is that the discourse can either be used as a means for empowerment or exclusion.
- The activist discourse: This discourse goes beyond the ethical and legal discourses and grounds itself in the awareness and knowledge distribution of the disease with the aim of empowering people and the aim of prolonging life. Under this discourse, treatment (ARV or ART) was encouraged and fought for (Seidel, 1993: 177).

There is one discourse that Seidel does not touch on. This is the spiritual discourse. How is illness viewed from a Christian Spiritual Approach? What is clear in this approach are the theological notions of sacrifice and unconditional love. Both of these principles are grounded in the eschatological identity in which unconditional love and other internalised virtues (charity, prudence, compassion, patience, humility, faithfulness, courage, temperance, sincerity and embodiment) are a consequence of the eschatological identity and not a precondition (Louw, 2008: 279-281). In this approach moral sensitivity and love as consequence of the eschatological identity is intricately linked to the issues of justice and human dignity. Virtues play a decisive role in this moral sensitivity and awareness and it therefore represents the moral awareness, humanity's moral network of doing, being and living (Louw, 2008: 280).

Seidel concludes that HIV is not merely an illness, but an issue of; "human rights, gender, public health, ethics, development and discrimination (Schmid, 2006: 98). It is safe to deduct that there are many factors that complicate the issues of HIV and AIDS and widespread behaviour change, these include socio-economic conditions of poverty, unhealthy gender roles, violence, lack of information, and unequal access to quality healthcare services. As noted, a factor that has not received adequate attention is culture and philosophical frameworks and discourses determining the understanding of diseases, their causes and appropriate methods of prevention (Benn, 2002: 3).

Benn argues that the discourses people hold are influenced to some degree by at least three different frameworks: the scientific, the religious and the traditional. All three of these frameworks of thought provide different interpretations of HIV, its origins and appropriate methods of overcoming it (2002: 3). The study will be exploring these in an attempt to understand the conflicting discourses relative to these frameworks; in the hope of gaining insight into the factors contributing to the HIV epidemic.

Many positive preventative interventions have been developed and have proven to be effective in many countries. Among these are education interventions, such as:

- Information on HIV and AIDS in conjunction with methods that enable individuals to combine knowledge with safer sexual behaviours.
- Life-skills education programmes at school.
- Peer group education programmes amongst, for example sex workers.
- Involvement of people living with HIV and AIDS (PLHA) (Benn, 2002: 5).

Technical interventions, such as:

- Social marketing of condoms
- Improved management of STI's (Sexually Transmitted Infections)
- Voluntary Counselling and Testing campaigns (VCT).
- Prevention programmes for mother-to-child-transmission (pMTCT) with antiretroviral drug intervention and modification of breastfeeding (which is encouraged today).
- Harm reduction programmes, e.g. needle exchange for intravenous drug use.
- Securing blood supply by testing all blood transfusions for antibodies to HIV (Benn, 2002: 5).

It can be argued that these intervention programmes were effective against the epidemic before the introduction of anti-retroviral treatment (ARV or ART) in numerous places such as Europe, North America, Brazil, Thailand, Uganda and Senegal. The challenge one is faced with now, is to implement effective programmes in countries where the HIV and AIDS epidemic has not been taken control of; effectively, aiming to explore and remove the existing barriers that prevent the successful implementation of a well-designed approach to the HIV and AIDS epidemic in the realm of care and prevention (Benn, 2002: 5).

Undoubtedly, sustainable impact and success of the above interventions was attained in countries that addressed the problem openly and early enough in the epidemic; with the main focus on stigma reduction, the protection of human rights and of the infected and affected population. In accordance with this, a strong political system that was able to implement the intervention strategies also contributed to the success of the intervention (Benn, 2002, 6)

In this research, the study will be looking at the impact of the neglected issues relevant to interventions. The investigation of the neglected issues might assist in comprehending why interventions were not successful in all countries and all social structures and cultures. These neglected issues in interventions might be playing a formidable role in impacting the epidemic. The neglected issues the study plans to look at are: (a) cultural perceptions of the disease, (b) perceptions of its cause and origin, (c) and perceptions of sexuality and its moral connotations with regards to transgression in particular societies (Benn, 2002: 6).

To assist the investigation of the neglected issues referred to above, the research will be exploring three perceptual frameworks. Through utilization of these frameworks one might be able to grasp why some countries had delayed or inadequate reactions and why so many individuals have not changed their behaviour despite receiving the correct information.

2.5.3 Three Frameworks

2.5.3.1 The Scientific Framework

This framework has been highly influenced by the developments in medicine and technology in response to the HI-virus. Under this paradigm it is understood that nature is

phenomenon that follows certain rules that are uninfluenced by the metaphysical powers of the world. Moreover, outcomes are determined by the calculated probabilities and possibilities using statistical methods (Benn, 2002: 6).

Scientific clinical research on diseases has assisted in the development of methods to help identify the virus that causes AIDS and developed treatment that helps in the impairment of the multiplication processes of the virus. These have been implemented in public health interventions and have proved to be a great tool in examining the effects of prevention strategies (such as condom use advocating) in countries who received treatment and countries that did not (Benn, 2002: 6). However, intervention aimed at populations living in particular cultural contexts cannot simply be compared to similar programmes in a different cultural context, as interventions should be adapted and sensitive to the cultural contexts and existing cultural discourses of communities.

Benn explains that only three interventions proved to be universally successful across contexts in the effective interventions to disrupt heterosexual HIV transmission (2002: 6).

- Peer group interventions amongst sex workers.
- Interventions amongst males in high-risk heterosexual behaviour.
- Increased management of STI's (Benn, 2002: 7).

Benn suggests that funds should be allocated towards implementation of the above interventions (2002: 7). It should be noted that under this scientific framework, no provision was made for the inclusion of other factors that might influence interventions. Factors such as culture and religion might play an important role when determining sexual behaviour and solutions in one region are not necessarily as efficient in an alternate region (Benn, 2002: 7). Although the scientific paradigm has contributed to multiple advances in combat of the HIV epidemic, it seems unlikely that it will lead to substantial and sustainable behaviour change if implemented in isolation.

2.5.3.2 The Religious Framework

In contrast to the scientific framework, the religious framework refers to a metaphysical entity that cannot be proven or disproven and is believed to be in constant interface with human beings. Despite the substantial variety of denominations, particularly in Christianity, the central religious framework is based on the assumption that there is a

God that influences creation and history and has made Himself accessible through prayer (Benn, 2002: 7).

The religious framework impacts on the understanding of disease. Particularly disease that is consequential of immoral sexual behaviour – disease such as HIV and AIDS and STI's. It therefore has consequences for the religious understanding of HIV and AIDS. Religious norms and discourses regarding human sexuality are surprisingly similar across differing religions. Muslims, Jews and Christians and some other religions constitute marriage as the rightful place for sex and sexuality. Within these religious spectrums, strict norms and values about pre-marital sex and abstinence as well as faithfulness to a spouse become crucial in sexual morality (Benn, 2002: 7). Most would argue that any deviation from these sexual moral ideals are to be condemned, but in a more pastoral approach would be grounded in the assumptions that humans are all sinners and provisions should be made to assist those who fail and fall into sin (Benn, 2002: 8). This links to the previous statement made under point 2.4; HIV and AIDS expose the deviation from sexual moral ideals, as HIV unmasks sexuality as a public and socio-cultural phenomenon. What used to be a private affair, now affects the entire community. If there is a sinner in the community that deviated from the sexual moral ideals and became HIV positive, does that make the entire community HIV positive? Is the HIV positive to be condemned (Louw, 2008: 424)?

The exploration and comprehension of these frameworks has a tremendous impact on, and are of utmost importance for the churches in Africa and their approaches to HIV and AIDS. Many churches still reject the notion of condom use since it is presumed to be undermining of the ideal perceptions of sexual morality. Moreover, deviation from the sexual moral ideal becomes the denial of the ideals for sexual morality. Within this framework, condoning the use of condoms is condoning sexual immorality. Thus, condoning sexual immorality means society is allowing sex before marriage, promiscuity and adultery (Benn, 2002: 8). In contradiction, for some people the use of condoms are ethically required; depending on the sexual relationship, these functions in accordance with the knowledge of the realities of the modern world, as well as the given social environment.

Opinions differ within churches as the Roman Catholic Church has, until recently, openly rejected the use of contraceptives. Although there have been Catholic ethicists

that argued for the use of condoms in certain situations, as the negative consequences should equally be avoided (Benn, 2002: 8). This said, Benn states that Catholics usually refer to; 'the principle of double effect: If an action has different effects, priority should be given to the one with greater moral appeal, in this case, the protection of life through the use of condoms" (2002: 8). Therefore, the question arises; what is more important, sexual morality or right to life? Another, more applicable question in this sectional discussion; does the proclamation of sexual restraint lead to less high risk sexual behaviour amongst Christians? The ecclesial identity of man becomes blurred if viewed in conjunction with HIV and AIDS. HIV and AIDS tests and challenges the idea of 'us being the church' (Louw, 2008: 424). In other words, if the people in the church are HIV positive, does that mean that Christ's body is HIV positive too? This poses the difficult question; is there room for the HIV positive individual in the community of believers? Moreover, how unconditional is Christian love really, when one considers HIV? This is a difficult question as different morals and ethics, communicated through discourses, might be resulting in exclusion and marginalization of people living with HIV and AIDS.

Garner states that religious groups often make use numerous instruments to influence the behaviour of church members (1999: 6-7). These instruments include, (a) *indoctrination* - persistent advocacy of values and norms shaped by the sacred text – (b) *religious experience* - collective participation of group functions in combination with subjective stimulus - *socialization* - frequent meetings and intrusive enquiry into lifestyles of members - and *exclusion* - self-definition of a group as separate from community as well as the exercise of disciplinary procedures (Garner, 1999: 6-7). It should be noted that although all these mechanisms are present in all churches, the degrees of implementation and function of these instruments differ (Benn, 2002: 8). In light of this, one is compelled ask; what are the HIV and AIDS discourses in the church? Moreover, how are these discourses affecting the practical response of the church to the HIV epidemic?

It is important to understand the discourses of religion and the church so one can understand the impact of the church's teaching on HIV and AIDS in society. The church is considered an important source of information and education, therefore the church remains a crucial agency for interpretation of event and for raising awareness about social happenings (Schmid, 2006: 92). Secondly, activities in the church are discourse based as activities mirror discourses and are reciprocally determined by it. Regardless of the

loss of economic and political power, the church's power stretches beyond the congregation; as the voice of the church has social power in the realm of human morality, even in secular societies (Schmid, 2006: 92). If one looks back to the early days at the rise of the HIV epidemic, Falwell formulated that AIDS was the punishment of God for sinners and for the immorality of society; particularly for the sin of homosexuality and the tolerance thereof in society (Schmid, 2006: 92). These formulations constituted the grounds for discourses that are still active in society. Even today, there are people living with HIV that stay away from the church because of discourses like these that constitute perceptions, stereotypes and marginalization of the other. This again links to the statement made under point 2.4; the people in the church make up the body of the church. The ecclesial identity of the church becomes confused here; should there be a person living with HIV in the church, does that mean the body of the church is HIV positive too (Louw, 2008: 424)? If the person living with HIV is no longer in the church, does the status of the body of church change?

While it is known that there are strong connections between what people say and what people do, what is said (or what is left unsaid) in the church about HIV determines the responses available. It has become evident that knowledge about the phenomenon does not necessarily translate into action. Nevertheless, there is a slim chance for change if no knowledge is present; however, it is not in itself enough to ensure behaviour modification.

Sexuality and death become interlinked, enmeshed and ultimately distorted concepts if one looks at their understandings in the context of HIV and AIDS. The understandings of the concepts sex and death play an important role when dealing with HIV and AIDS. Both the concepts of death and sex are bordered by powerful taboos and both concepts are ritualised within cultural contexts (Schmid, 2006: 93). Maluleke stresses the importance of trying to understand taboos in their contexts, instead of forcing people into as state of ignorance about taboos (2000: 99).

In understanding HIV and AIDS from the religious framework discussed above, one can gain many relevant insights. It can be noted that many Christian groups have engaged themselves in the fight against HIV and AIDS, pioneering courageous efforts to assist people living with and people affected by the disease. Unfortunately, it is argued that many Christian doctrines have also contributed to discrimination, fear and stigma-

tization – fuelling against the success of prevention intervention programmes (Benn, 2002: 9). However, there is the hope that this could be overcome by comprehension of all different interpretations of HIV and AIDS and the exploration of all existing attitudes towards the HI-virus and people living with and HIV positive status (Benn, 2002: 9).

2.5.3.3 The Traditional Framework

The most influential framework on the existing discourses surrounding HIV and AIDS is undoubtedly the traditional framework – particularly in the context of African spiritualities (Benn, 2002: 9). The traditional framework can be understood as the cultural or spiritual framework, as it draws relevance to the spiritual and cultural (traditional) frameworks of understanding HIV and AIDS.

When considering African Spiritualities, studies have shown that traditional healers will most often be approached before a medical practitioner. Moreover, people seem to rely on the advice of the traditional healer with regards the interpretation of disease and personal behaviour (Benn, 2002:9) However, one must never deduct that this behaviour renders African people as backward or irrational. Instead, one must acknowledge that the scientific framework does not provide satisfactory answers for people in all contexts. It is maintained that the theories surrounding HIV transmission and prevention is not soundly grounded and accepted by all; as no empirical knowledge about the origin of the virus can be maintained and there is no concrete hope for a cure (Benn, 2002: 9). In the observation of the massive mortality rates in many communities, one is then forced to look for alternate answers for the constant problematic questions raised by HIV and AIDS. In support of the above statements, let's consider the following quote by Yamba:

Rural Africans now find themselves the target of three competing and contradictory discourses about responsibility, each of which claims to tell them how to lead safe lives free from AIDS. The first, represented by the biomedical paradigm, profess sure knowledge about the aetiology and epidemiology of HIV and AIDS but is unable to cure it; the second, the missionary discourse, preaches abstinence and encourages a revival of traditional beliefs and rules of morality as the only way to manage and survive AIDS; while the third is a traditional discourse – represented by traditional healers and

witch finders – which profess sure knowledge and the ability to eradicate evil (1997: 222-223).

In his extensive research of HIV and AIDS in Zambia, Yamba found that numerous of the Zambian people believe that evil is intentional and not accidental. Should something prove to be harmful, the explanation of witchcraft is resorted to. There is a fatalistic fear that things are like this and are intended to happen (Yamba, 1997: 222-223). Hence, interpretations and discourses on disease and evil need to be considered in more depth, as the more Western-secular paradigms - intervention programmes are rooted in - do not make provision for this way of thought. This becomes a formidable problem as African traditional thinking might not be capable of delivering the liberation which people deserve (Yamba, 1997: 222-223). The question is then; does African traditional thinking create any possibility for a solution to the HIV and AIDS problem?

2.6 CONCLUSION

Consequently, it is safe do make the deduction from the above that HIV and AIDS discourses are grounded in culture, traditional beliefs and worldviews. Let's now explore how these traditional beliefs and conflicting worldviews influence practical HIV and AIDS prevention programmes – with particular reference to condom use as safer sex practice.

Within the scientific framework, condoms are considered to be a highly affective biomedical intervention in the prevention of HIV transmission. "Scientific evidence shows that latex condoms are highly effective in preventing the transmission of HIV and some other STI's when they are used *consistently* and *correctly*." Furthermore, Condoms have been proven to be 99.7% defect free (Van Dyk, 2012: 176). In addition to these facts, a study of 124 discordant (one HIV positive and one HIV negative) heterosexual couples that used condoms consistently and correctly during sexual intercourse, it was found that *no* transmission occurred (Van Dyk, 2012: 176). The risk of transmission for discordant couples who use condoms consistently and correctly is 85% lower than couples who do not use condoms as a safer sex alternative (Benn, 2002: 12). Regardless of the biomedical successes of condom use, it can be noted that numerous religious leaders state that because condoms are not 100% effective, they are not considered the solution.

As cited in Benn, the World Council of Churches stated that they recognize the reality of human sexual relationships and practice and the existence of HIV in the world, without encouraging promiscuity. Furthermore, they stated that they acknowledge the role of education on positive measures of prevention and the role of provision and use of condoms in the prevention of transmission of the virus and the prevention of consequent suffering and death for many of those infected and affected (2002: 13). In the light of these facts, is it not yet time for churches to recognize the use of condoms as a method of prevention of HIV? (Benn, 2002:13).

In an African traditional framework, the use of condoms takes on a different dynamic; condoms do not seem viable as a defence or prevention if it is presumed that disease is in fact a product of witchcraft and sorcery. Moreover, personal behaviour and responsibility would not help under this framework either, because the forces that cause illness are outside the control of the individual and mere change in personal behaviour will not influence the results (Benn, 2002: 13).

One can securely state that condoms are not very popular in Africa, despite the increased awareness and knowledge of HIV and AIDS. The lack of condom use in Africa is often incorrectly recorded by Western authors and was consequently ascribed and to promiscuity, permissiveness and lack of moral and religious values. This has proved to be a result of misunderstanding the African philosophy behind sexuality and disrespect for African cultural beliefs (Van Dyk, 2012: 225). There are deep rooted cultural beliefs behind condom non-use in the African context.

In Rwanda condom non-use proved to be the product of a particular cultural stance; where the belief is held that the sharing of body fluids during sexual intercourse was an exchange of the ‘gifts of the self’. This sharing of the ‘gift of self’ is of utmost importance in a relationship and is also considered as an indication of fertility. Furthermore, a fear was held by women that the condom would ‘stay behind’ and cause a permanent ‘blockage’ against fertility. Similarly, South African women proved to have coinciding fears about condom use, because of the fear that the condom might stay behind and suffocate them by moving through the body to the throat (Van Dyk, 2012: 226). Existing cultural beliefs about sexuality needs to be investigated and ultimately encouraged, should they prove to be a safer sexual behaviour.

Another culturally grounded belief worth considering is the 'ripening of the foetus'. Under this discourse, it is believed that the foetus needs repeated contributions of semen from the father in order to grow or 'ripen' in the womb. It is therefore not only believed that condoms are 'unnatural', but is also believed that condoms interfere with the growth of the foetus (Van Dyk, 2012: 226). Furthermore, it is believed that semen hold necessary nutrients and vitamins for continued physical and mental health and the fertility of women (Van Dyk, 2012: 226). In light of this, using condoms is in fact 'wasting sperm' and is therefore not a common practice. Schoepf founded that this discourse was grounded in the notion that the ancestors meant for the fathers to take an interest in the pregnancy and not run out on pregnant women while they await the birth of her children (1992: 231). It is argued that AIDS education programmes should address these ideas on beliefs to inform people about the truths without denouncing the importance and validity of one's culture and beliefs one might hold.

These interpretations and perceptions of condoms and discourses surrounding HIV need to be taken seriously in the future development of HIV intervention programmes. The three frameworks discussed here assist tremendously in the understanding of the dynamics surrounding HIV and AIDS and the discourses perceptions of condoms are grounded in. They provide alternate explanations of the differing ways prevention interventions can be implemented (Schmid, 2006: 98). Ultimately, it enlightens why the virus has been to address the HIV epidemic effectively (Benn, 2002: 14) However, these parallel realities the frameworks are grounded in prove to be problematic for Africans.

It is safe to make the deduction that condoms are in fact being stigmatized within the realm of HIV and AIDS. In the above sections the research has explored the relevant cultural and religious factors, frameworks, discourses and perceptions that have constant influence on the HIV epidemic. In exploration of these perspectives, the research has gained insight as to why condoms are being stigmatized.

It was determined that the socio-cultural context is not being considered in the addressing of safer sexual practices and prevention strategy implementation. It also became clear in this chapter that collective action of communities is needed to adequately address the safer sexual alternatives (ed. Visser, 2007: 193).

It was also identified that mere knowledge about safer sexual practices does not necessarily translate into behaviour change, even if people believe they have the ability to have safer sex. This could be ascribed to the beliefs held about sex, condoms and sexuality; as this influences safer sex practice tremendously (Taylor, 2009: 378). Moreover, perceptions are constantly influenced by the social environment and cultural meanings attached to sexuality are considered a fundamental influence on behaviour patterns (Joubert-Wallis & Fourie, 2009: 105; ed. Visser, 2007, 191). Ultimately, human beings cannot be understood in separation from their cultural context (Louw, 2008: 153).

Certain discourses that influence the social understanding of illness and HIV and AIDS in particular were explored, also looking at discourses surrounding sexuality and perceptions about sex. Some interventions proved successful, yet some did not. Many countries responded inadequately (Benn, 2002: 6). In this chapter the study explored the discourses behind the unsuccessful approaches to the epidemic. The study also explored 3 distinctive frameworks that might have had influenced the different responses different countries had to the epidemic. These frameworks are: (1) the scientific framework; which looks at the medical advances and how they have been successful in the past. This assisted in determining the causes of AIDS and assisted in developing treatments. (2) Within the religious framework, the chapter looked at the religious discourses such as AIDS as punishment for immorality and punishment for society's tolerance of homosexuality. In the religious framework it was also noted that different church doctrines have different views and perceptions on sexuality and contraception (Benn, 2002: 8). Understanding the church's discourses will assist in understanding the impact of the church teachings on society, as the church is considered an important source of information (Schmid, 2006: 92). The last framework, (3) the traditional framework, was the most influential framework of the three frameworks. This framework explores how people identify with their traditional and cultural roots and how people from certain cultures would consult with a traditional healer before consulting a doctor or medical practitioner. Thus, looking at how some refer to a traditional frame of reference before referring to a scientific frame of reference. Certain discourses of evil as punishment for immorality and sin - within particular cultures – were also looked at in this framework. Consequently, the deduction was made that HIV and AIDS discourses are influenced by traditional beliefs, culture and worldviews (Yamba, 1997: 222-223).

One was also able to deduct that strong cultural and traditional belief systems influence the discourses pertaining to HIV and AIDS. Moreover, these discourses influence the attitudes people hold toward safer sexual practices, sexuality, HIV and AIDS and people living with HIV and AIDS. Discourses surrounding HIV and AIDS and perceptions of condoms need to be taken into account in the future development of intervention programmes (Schmid, 2006: 98).

This chapter therefore succeeds in answering the question of the Descriptive-Empirical task: what is going on with regards to the impact perceptions have on condom use? It has been determined that there are certain factors (beliefs and attitudes) that influence how people think about condoms and sexuality. These factors (beliefs and attitudes) ultimately influence the willingness of people to use condoms. It is then safe to say that the attitudes and beliefs people have about condoms are negative, and these attitudes and beliefs impact negatively on people's willingness to use condoms. Thus, the deduction is that people do stigmatize condoms.

In order to support and enrich this finding, the Descriptive-Empirical task will be extended to attend formally and objectively to what is going on, through exploration of the possible attitudes and beliefs impacting the stigmatization of condoms use. The research will also attend to the notion of knowledge and education and their impact on sexual practice. It was noted in the aforementioned that people are more likely to refer to their traditional and cultural frameworks first before referring to a scientific framework. The use of an empirical study will assist in the further enrichment of this concept. The empirical study will look at the participants' willingness to use condoms if the participants possess sound educational medical knowledge about HIV and AIDS. Although briefly mentioned before, the research will further explore the actual relevance and influence of educational knowledge. The study explores how influential education is in the process of decision making. The study also wishes to explore whether integration of educational knowledge is taking place. The empirical study will then assist in formally attending to this.

CHAPTER THREE

THE EPISTEMOLOGICAL ENDEAVOUR OF FORMAL ATTENDING: EMPIRICAL STUDY WITH EDUCATED MEDICAL STAFF

3.1 INTRODUCTION, AIM AND PURPOSE

The aim of the empirical study is to supplement and enrich the literature discussed earlier in the initial part of the Descriptive-Empirical task. As mentioned above the strategies of inquiry to achieve this, the research started off with an initial qualitative literature review and, herewith, follows with an empirical research study in order to attend to the question of what is going on? Through the use of a combined method of both qualitative and quantitative research the aim is to assist in attending to the topic comprehensively and objectively (Osmer, 2008: 38).

In the previous chapter - the initial literature review and first part of the descriptive empirical task - the research looked at the different discourses of religions and cultures. It also looked at how these discourses and attitudes impacted on HIV and AIDS. In the initial literature review and qualitative evaluation of the research question of what is going on, the research determined that people do hold strong stigmatized beliefs about condoms. Moreover, it was clear that the attitudes and beliefs people hold do not only influence people's views about HIV and AIDS, but imposes stigmatized views about condoms use. Furthermore, it was determined that the attitudes and beliefs people have about HIV and AIDS and condoms are negative and the attitudes and beliefs impact negatively on people's willingness to use condoms. Thus, it is safe to say that condoms are being stigmatized.

In the initial, qualitative, literature review, clear links were also found between social ideas about condoms and lack of knowledge and education. It was determined that discourses, cultural and religions, and even power dynamics influence collectively on the perceptions people have about condoms and HIV and AIDS. A few questions still linger after the enquiry of the qualitative literature review: What is the impact of knowledge attainment and education on the topic of HIV and AIDS? Are educational interventions enough to move towards de-stigmatization of perceptions? In other words

are these educational interventions adequate and relevant? Considering these questions, the research is obligated to look at the primary research question in more depth. Osmer's methodology provides a structure through which the research can more formally and objectively attend to this, as it allows for systemic and intentional enquiry.

Osmer explains that formal, empirical and objective attending allows researchers to deepen their understanding of what is going on in particular episodes, situations and contexts (2008: 39). In accordance with Osmer's methodology the empirical research in the Descriptive-Empirical task allows for a deepened understanding of what is going on with regards to the perceptions that are held about condom use. Thus, the empirical component of the epistemological endeavour proves to be particularly helpful in allowing interpretive guides to better understand the participants in the research as it assists in the interpretation and identification of trends that are impacting people's lives and shaping their context (Osmer, 2008: 41).

Ultimately, the purpose and goal of this chapter - the empirical study - is that the formal attending in this research study might assist in the further, deepened identification and interpretation of people's perceptions about condom use and explore how these perceptions are relevant to the phenomenon of HIV and AIDS and condom use. Furthermore, it allows ground for more formal exploration into the question of education and its influence on the perceptions, attitudes and beliefs surrounding condoms and HIV and AIDS. Finally, it also hopes to offer a conclusion for what is going on with regards to the perceptions people have about condom use and further assists in the formulation of the argument of the research study (Osmer, 2008: 42).

3.2 HYPOTHESIS

As mentioned, it was determined in the initial literature review that condoms are being stigmatized, and this stigmatization runs parallel to the stigmatized beliefs, attitudes and perceptions surrounding HIV and AIDS. But in order for one to formally attend to the research questions surrounding education and its influence on stigmatization, perhaps it is required that one briefly looks at what is meant by stigma, stigmatization and destigmatization, before the hypothesis formulation. This might assist in better comprehension on the proposed hypotheses. After Chapter Three, there will be a Chapter on Stigmatization (Chapter Four, see page 78), comprehensively discussing all of the rele-

vant dynamics of stigmatization of condoms in the realm of the HIV and AIDS epidemic.

Stigma's definitive is an attitude or quality that shames an entity, individual or group, in the eyes of another entity, individual or group. This means that people may have a negative attitude towards that entity, individual or group because of certain believed characteristics or traits (Brown *et al.*, 2011: 16). Because of stigma, certain entities, individuals and groups are often discriminated against, which often results in unequal treatment of the other. There are different kinds of stigma, namely internal and external stigma. Internal stigma is the stigma felt internally and emotionally by an individual due to external stigmas, which are stigmas that cause people to feel unfairly treated (Brown *et al.*, 2001:16).

Considering these definitions, stigma can be understood as a mind-set or a kind of thinking that is commonly negative. In its mildest form these negative attitudes towards HIV and AIDS in particular may manifest as indifference towards people living with HIV and AIDS (Van Dyk, 2012: 334). Van Dyk explains that more extreme negative attitudes also prevail and these include condemnation, labelling and stigmatization of people (2012: 334). This negative, stigmatized mind-set might even go as far a 'laager mentality' in which some communities completely distance themselves from people living with HIV and AIDS, often discarding these individuals from the community and disregarding their spiritual and physical needs (Van Dyk, 2012: 335). As a result, religious communities create a deliberate distance between them and the people living with HIV and AIDS. In turn people living with HIV and AIDS refrain from getting the spiritual and physical assistance they need. This not only affects their adherence to treatment but many of the most urgent and troubling existential questions of people living with HIV and AIDS are not addressed and this leaves a dire need for spiritual comfort and consolation (Van Dyk, 2012: 335). It is examples like these that represent the manifestation of stigmatized beliefs and attitudes towards those living with HIV and AIDS and in turn HIV and AIDS in itself. The need in the aforementioned is crucially important, but a small one in the scheme of the HIV and AIDS phenomenon. The need for the movement towards de-stigmatization can only be attained if negative beliefs, attitudes and perceptions that result in stigmatization, discrimination, denial, labelling and distancing are extensively challenged. In order to challenge the stigmas relevant to HIV

and AIDS one needs to investigate thoroughly, what the negative beliefs, attitudes and perceptions are. Those mentioned in the prior qualitative literature review. In this chapter the opportunity arises for formal and objective attending to these attitudes and beliefs in relation to HIV and AIDS, but focusing on the stigmatized beliefs, attitudes and perceptions surrounding condom use.

Working from the proposition that education is an empowerment tool in the struggle against HIV and AIDS, it was hypothesized that education is not necessarily effective in moving toward de-stigmatization of HIV and AIDS. Furthermore, it is also proposed that knowledge about HIV and AIDS does not necessarily translate into condom use to prevent sexual exposure to the HI-Virus (Taylor, 2009: 378). Therefore the questions one is faced with are; do educational interventions about HIV and AIDS and knowledge about the benefits of using condoms during sexual intercourse actually translate into condom use in practice? Do individuals that possess sound educated medical knowledge about the benefits of condoms use actually practice condom use as a preventative measure? Or are the stigmatized attitudes and beliefs about condoms affecting people's willingness to use condoms, regardless of their knowledge about the benefits thereof? The hypothesis is that stigmatized beliefs are affecting people's intention and willingness to use a condom and the findings of the empirical research in this study will prove that educated knowledge about HIV and AIDS does not necessarily motivate the use of a condom. Furthermore, the hypothesis is that variables such as attitudes, beliefs and opinions will weigh more than knowledge when it comes to decision making about safer sexual prevention options amongst educated medical staff.

Why *educated medical staff,* and not an uneducated sample group? This opens ground for future enquiry and another hypothesis for a different research topic. If one identified strongly held stigmatized beliefs, attitudes and perception amongst educated medical staff that have access to educational resources about condom use HIV and AIDS, could it be argued and hypothesized that one would find stronger held stigmatized beliefs, attitudes and perceptions amongst an uneducated sample group, with no educated medical knowledge. Furthermore, if it is determined that educated medical staff does not use condoms because of these strongly held stigmatized perceptions, would one not then be able to argue that their uneducated counterparts are even less likely to engage in condom use? This brings forth the final hypothesis; as one expects that stigmatised beliefs,

attitudes and opinions about condoms influence people's inclination to, or not to use condoms and/or motivate and cause them to advise/warn others against such usage.

3.3 RESEARCH METHOD

Under this section the empirical process will be explained.

3.3.1 Participants

For the empirical study, a sample group was drawn from the educated medical staff from a private Western Cape Hospital. The reason why the sample was drawn from a hospital's educated medical staff derived from the assumption that the sample will be drawn from participants who have been educated and have sound medical knowledge on the topic of HIV and AIDS, and therefore know the preventative benefits of condom use. Permission was obtained from the Human resource department to draw a sample group from their educated medical staff and permission was obtained to conduct an empirical study of this nature (see Addendum C; Hospital permission letter).

Participants were all presumed to have sound medical knowledge on the topic of HIV and AIDS and would therefore understand the preventative benefits of condom use. The participants were older than the age of 18 and were all from different socio-economic groups, age groups, religious and ethnic groups, different language groups, living areas. Some of the participants were married and some unmarried and there were male and female participants taking part in the study.

3.3.1.1 Inclusion Criteria and Ethical Considerations

The inclusion criteria was that participants had to be older than 18. No participant information was included in the data without the submission of both the informed consent and the empirical questionnaire. It was required of the participant to carefully read and sign the informed consent before completing the questionnaire, to ensure that the participants were duly informed of the purpose, aim and structure of the study.

All of the participant information was kept confidential and the empirical questionnaires were anonym. The data collected was also carefully controlled by the researcher and kept in an access controlled area after the research was completed. The data was shared with a small researching team, namely the researcher, the statistical analyst and

the research supervisor; still anonymity was maintained, as the identities of the participants were not revealed to the research team (only the researcher). As mentioned in Chapter One, the application for ethical clearance to conduct this research was approved by the Research Ethics Committee: Human Research (Humanities) (See addendum D).

3.3.2 Data Collection

3.3.2.1 Empirical Questionnaire

*See Addendum A1 and A2

A multiple choice structure questionnaire was administered to gather the data form the participants. The multiple choice structure questionnaires were developed by the researcher after careful consideration of the possible demographic and attitudinal criteria that might impact on the participants' willingness to use condoms.

The participants were asked to complete the questionnaire by circling the option that best suited them. The questionnaire had three parts. The first part of the questionnaire held an introduction explaining the purpose, aim and process of the study. This part of the questionnaire also briefly explained the structure of the questionnaire and the application of confidentiality and anonymity. All of these concepts were elaborated on in the informed consent.

The second part of the study held the measurement of the demographic criteria of the participants. The demographic data measured was Age, Ethnic Group, Language, Gender, Socio-Economic Group, Marital Status, Religious Group and Living area. The demographic criterion was measured to gain some insight on the cultural demographics - as Religion, language, ethnicity and age indicate certain cultural affiliations - of the participants and correlate these demographics with the attitudes selected and the willingness of the participants to use condoms. In this part of the study, the participants were asked to select *only one* of the answers most applicable to them.

The last part of the questionnaire measured the attitudinal perspectives of the participants as well as their willingness to use condoms. In this part of the study, participants could select *as many answers as they thought were applicable* to them. The data in this

part of the questionnaire was divided into reasons for using condoms and reasons for not using condoms.

3.3.2.2 Informed Consent

*See Addendum B

The informed consent was administered at the same time as the empirical questionnaire. The informed consent was signed by submitted by every participant. The purpose of the informed consent was to ensure that all of the participants were well informed of the purpose and process of the study and informed on the nature of confidentiality and anonymity. The informed consent also explained the potential risks and discomforts, as well as the potential benefits to the subjects and benefits of the study to society. The informed consent discussed the participation of the study, also explaining the process of withdrawal from the study at any time, also looking at the rights of the subjects. The contact details of the researcher and the research supervisor were provided should the participants have any queries.

The informed consent explained that no participants would be compensated for their participation in the study. It further explained that there was little-to-no risks involved in participating in the study. The informed consent also explained that the participants were free to discontinue their participation in the study at any point during the research.

After completion and collection of all the participant's studies and informed consents, the data was collected and statistically analysed to draw the following correlations and findings.

3.3.3 Data Transcription

3.3.3.1 Demographic Data Transcription

The Data of this research assignment was transcribed by Stellenbosch University's Faculty of Economic and Management Sciences. The transcription of the data indicated the following:

Of the participants taking part in the survey, demographic information was also collected in the survey. The demographic criteria listed as follows:

a) Age
b) Gender
c) Ethnic Group
d) Home Language
e) Socio-Economic Group
f) Living Area
g) Marital Status
h) Religious Group

After analysis the demographics were as follows: 69% (29) of the participants were of the age group 30 or older. 21% (9) of the participants were between the ages of 24-30. 5% (2) of the participants were between the ages of 22-24 and the last 5% (2) participants were between the ages of 18-21 (See Figure 3.1). Of these participants, 12% (5) were males and the other 88% (37) were female (See Figure 3.2). The inconsistency of figures between the male to female ratio could be ascribed to the job profession; as many of the participants were nurses, which is a predominantly female career.

Figure 3.1: Histogram of Age Group

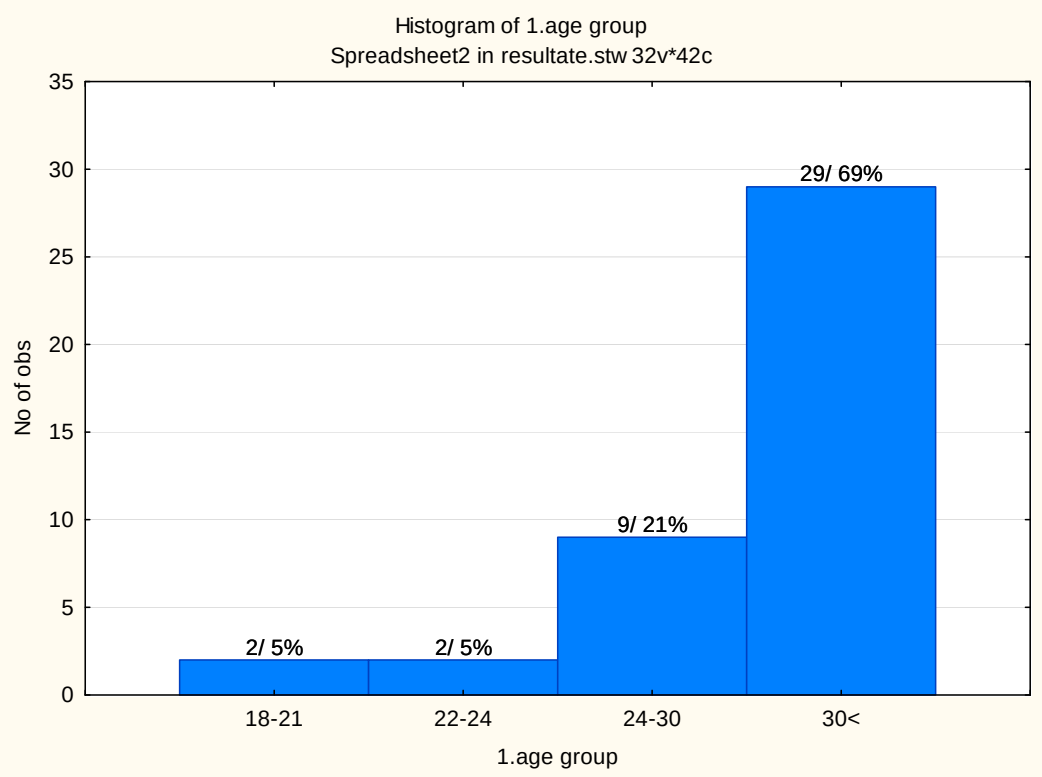
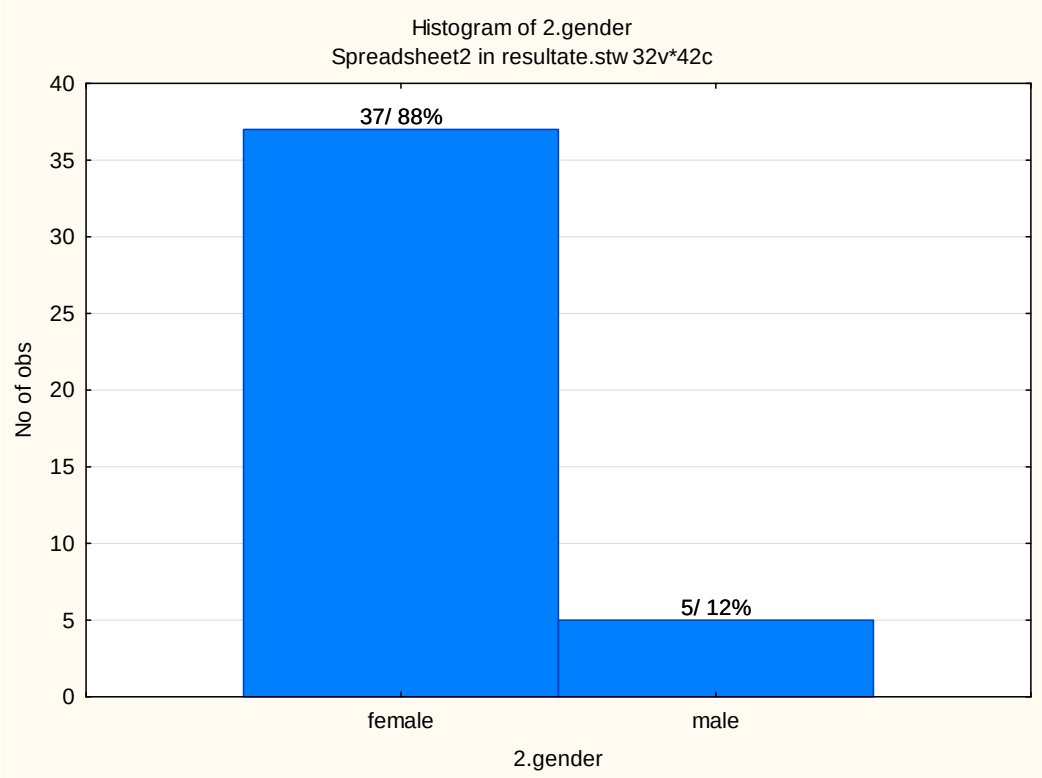


Figure 3.2: Histogram of Gender



In the measure of ethnicity, 40% (17) were Caucasian participants, 5% (2) participants were Black and the majority of participants, at 55% (23) were Coloured (See Figure 3.3). Home language was another demographic measured; the majority of the participants were Afrikaans with a percentile of 57% (24). 38% (16) of the participants were English speaking in their home language and 5% (2) participants were Xhosa speaking in their home language (mother tongue) (See Figure 3.4).

Figure 3.3: Histogram of Ethnic Groups

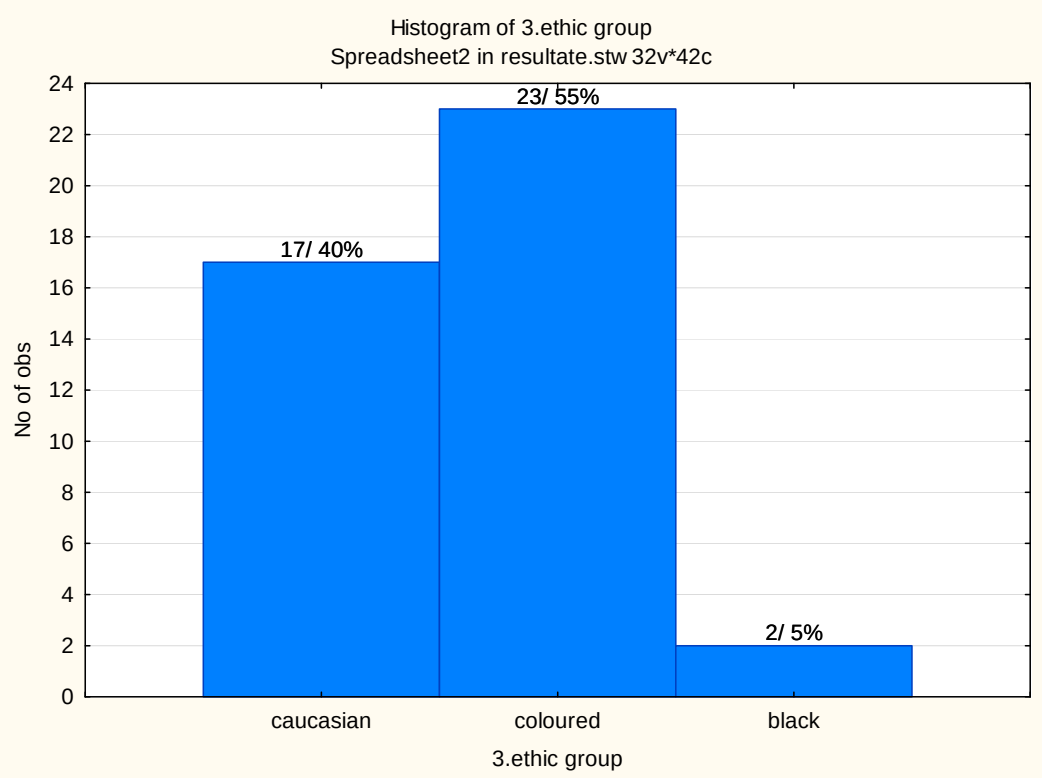
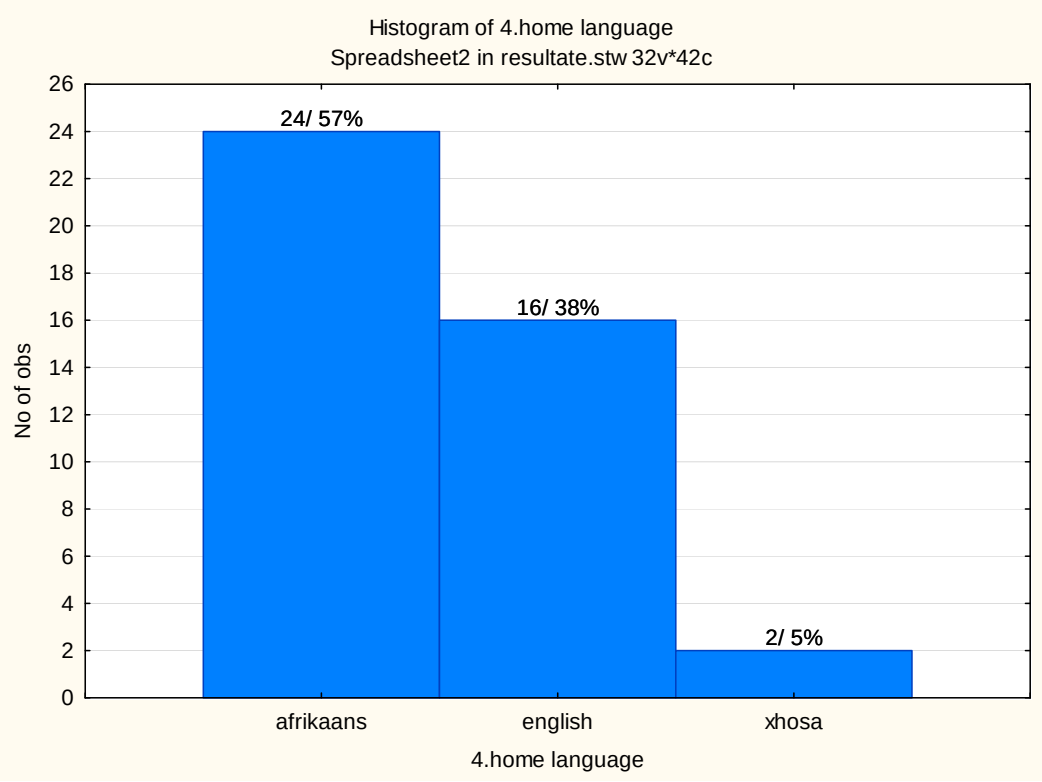


Figure 3.4: Histogram of Home Language



In the socio-economic demographics, 48% (20) of the participants identified themselves as working-middle class, 5% (2) as upper-middle class, 2% (1) as upper class. 26% (11) of the participants identified themselves as middle class and the other 19% (8) as working class (See Figure 3.5). The living area demographics recorded the following: the majority of 45% (19) participants reported urban living, 43% (18) reported formal sub-urban living, 7% (3) participants reported rural living and 5% (2) reported living in an informal rural area (See Figure 3.6).

Figure 3.5: Histogram of Socio-Economic Group

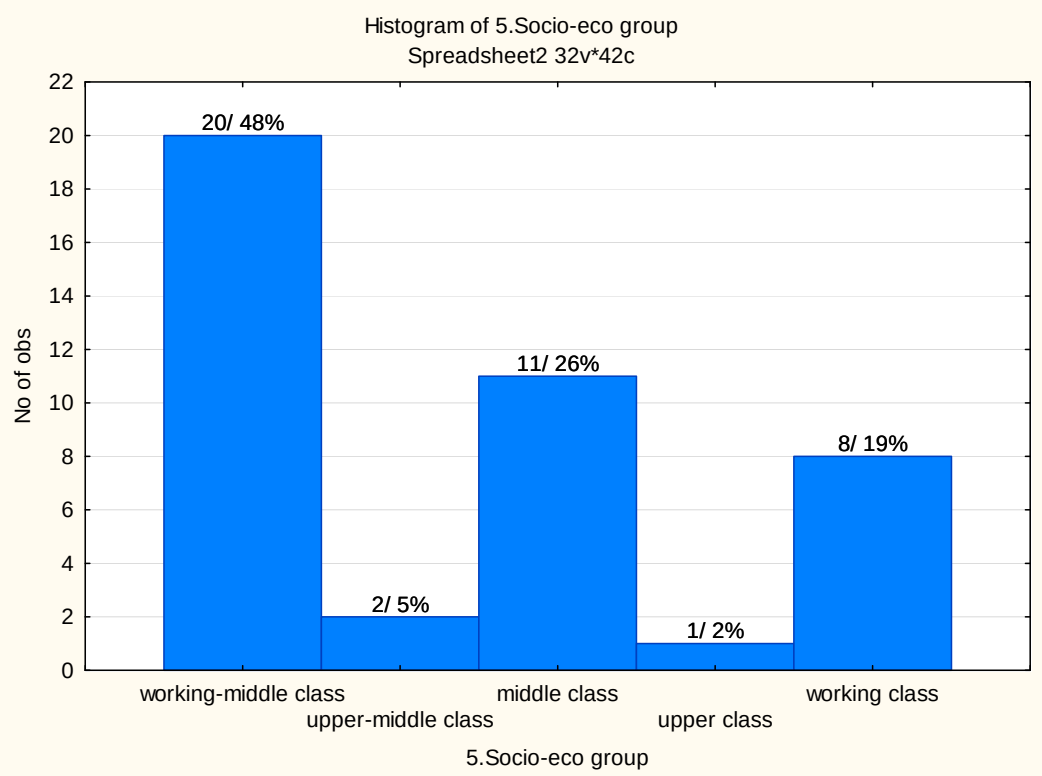
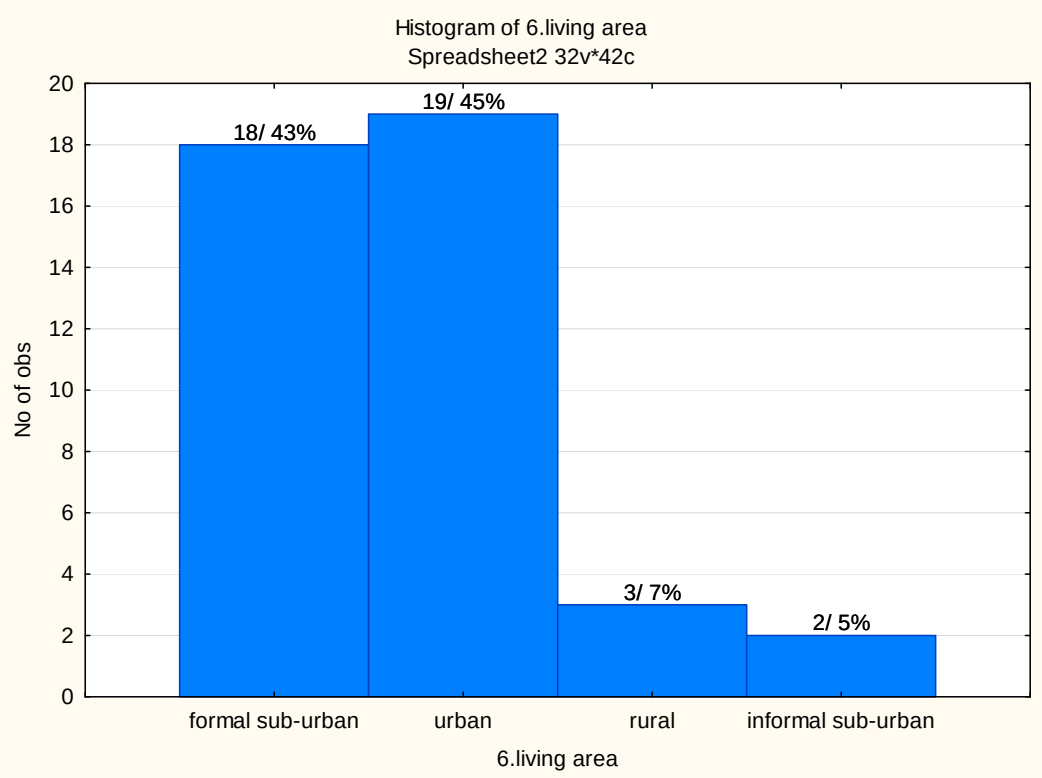


Figure 3.6: Histogram of Living Area



Of the voluntary participants 40% (17) are unmarried (single), 36% (15) are married, 21% (9) are divorced and 2% (1) of the participants were widowed (See Figure 3.7). Under the exploration of religious demographics, 81% (34) of the voluntary participants reported being protestant, 12% (5) were recorded as Catholic, 2% (1) identified themselves as belonging to no religious affiliation and 5% (2) reported that they had 'other' religious affiliations (See Figure 3.8). Of the 81% of Protestants majority of participants reported affiliation with the Dutch Reformed Church, the United Reformed Church, the Old Apostolic Church and the Anglican Church (See Figure 3.9).

Figure 3.7: Histogram of Marital Status

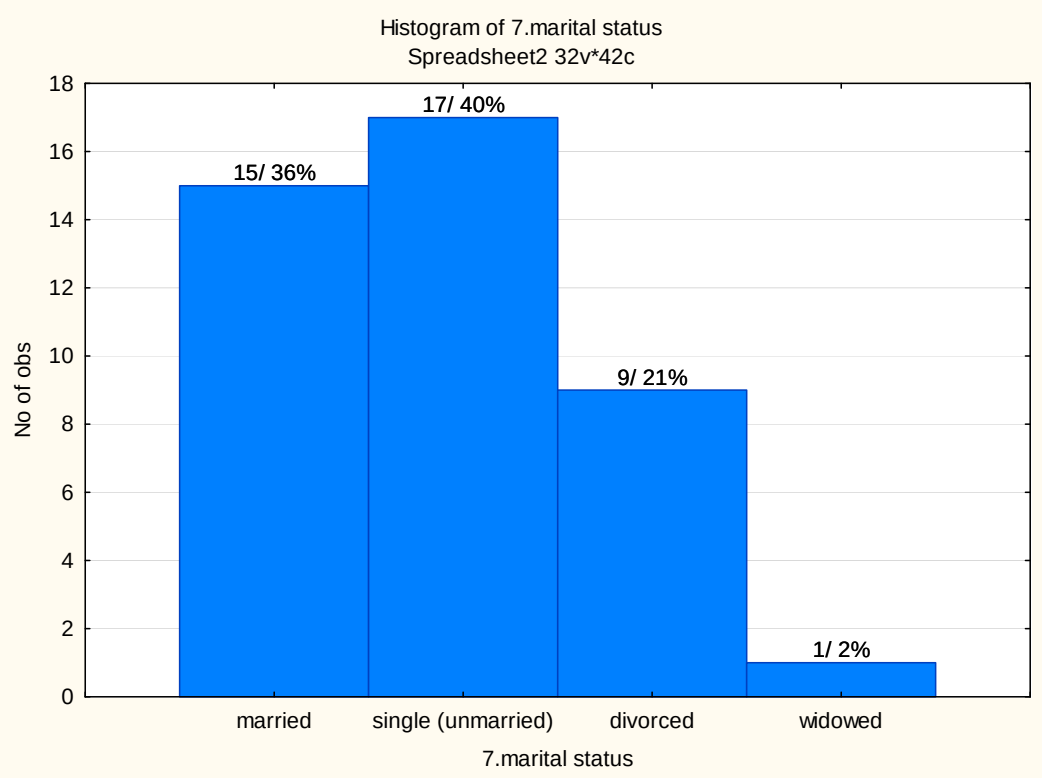
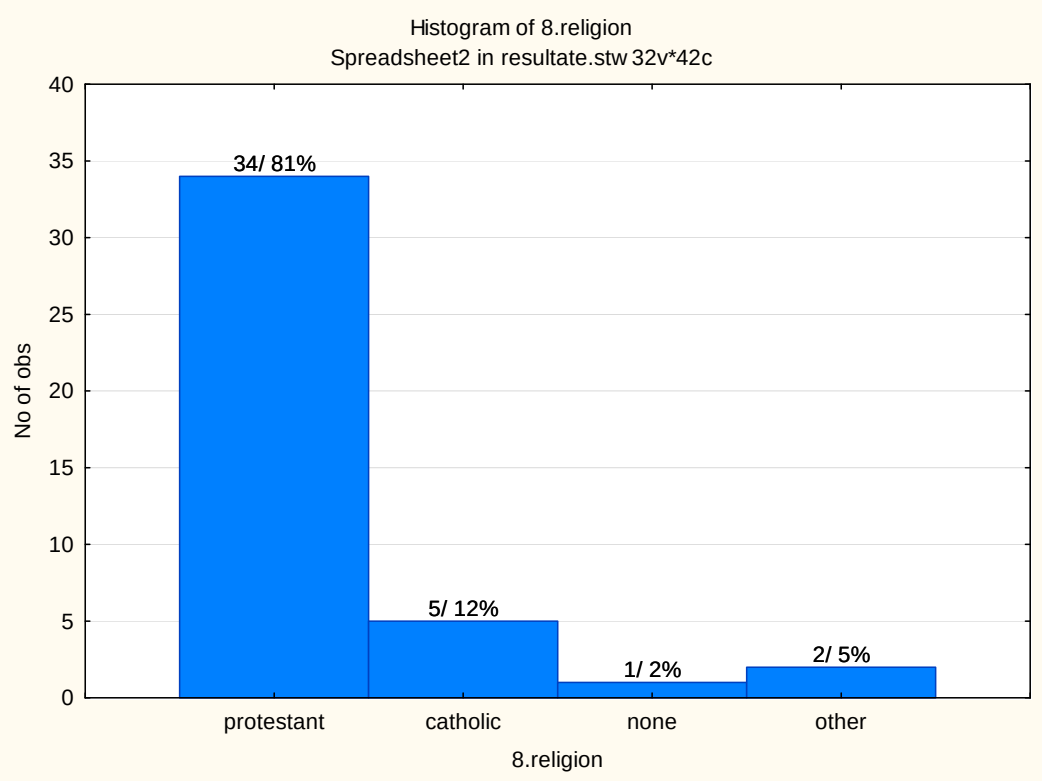


Figure 3.8: Histogram of Religion



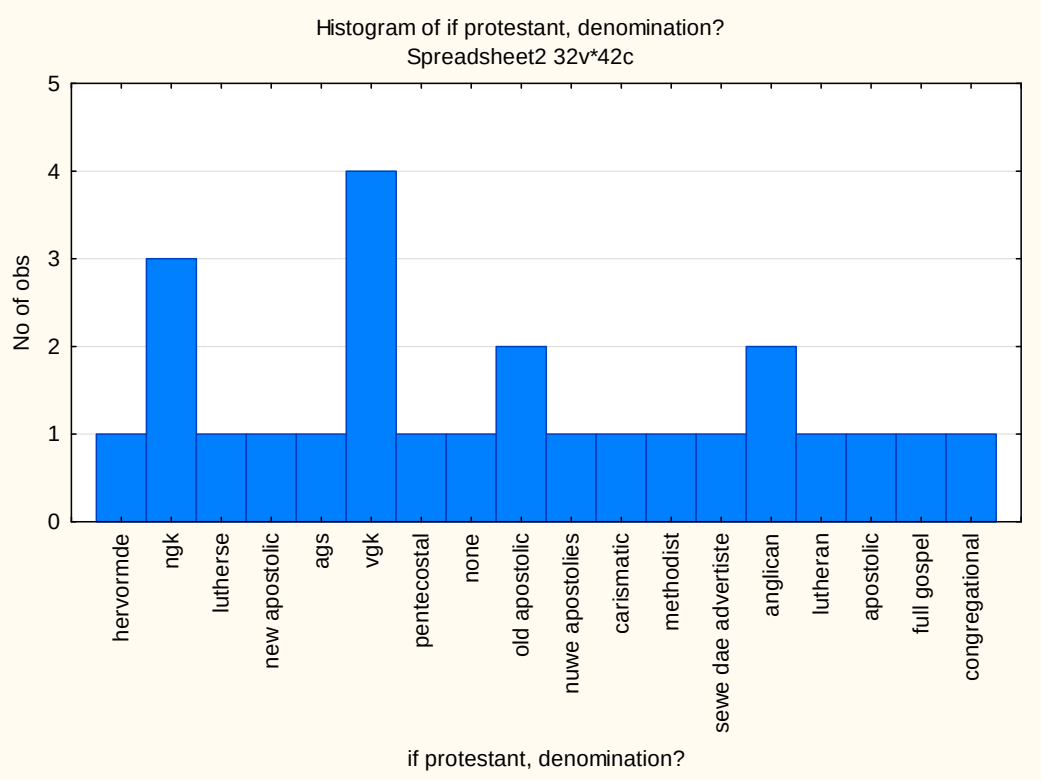


Figure 3.9: Histogram of Protestant Denomination

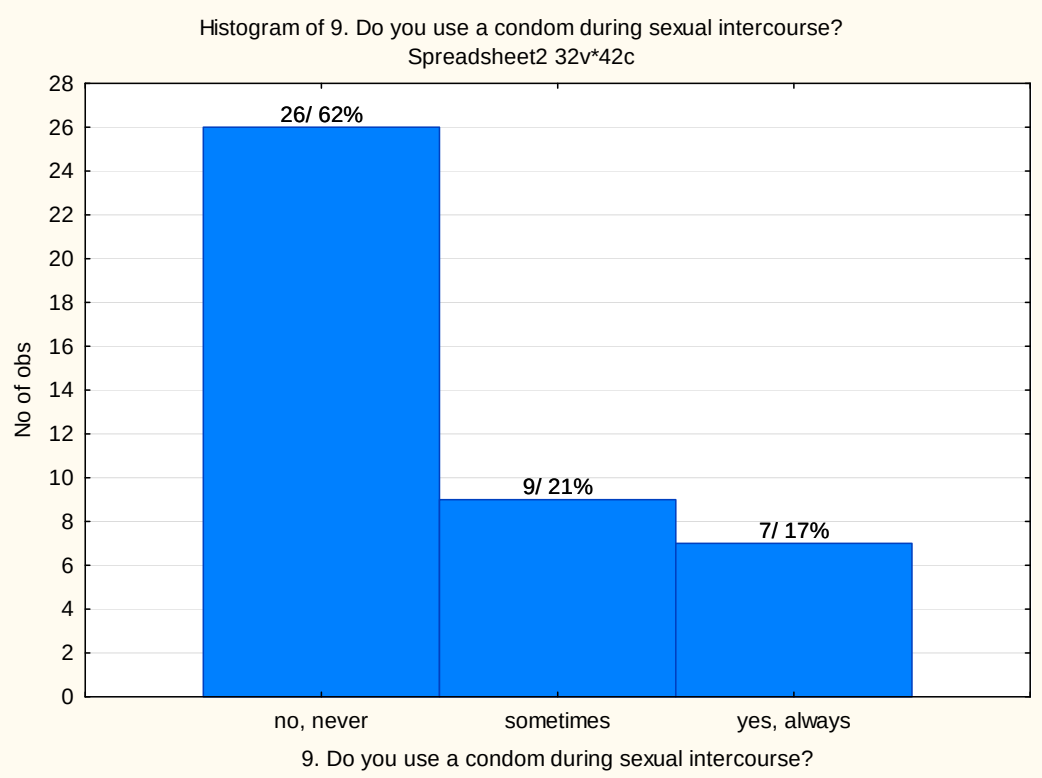
3.3.3.2 Attitudinal Data Transcription

The second section of the survey focused on condom use and the attitudes the participants had toward condom use. Some of the attitudinal answers under the second section were derived from the UCLA Multidimensional Condom Attitudes scale, but was also inspired by numerous other qualitative attitudinal condom studies.

After statistical analysis of the survey, the following results were obtained from the second section of the survey. In this analysis, the consistent use of condoms and the attitudes towards condom use were considered.

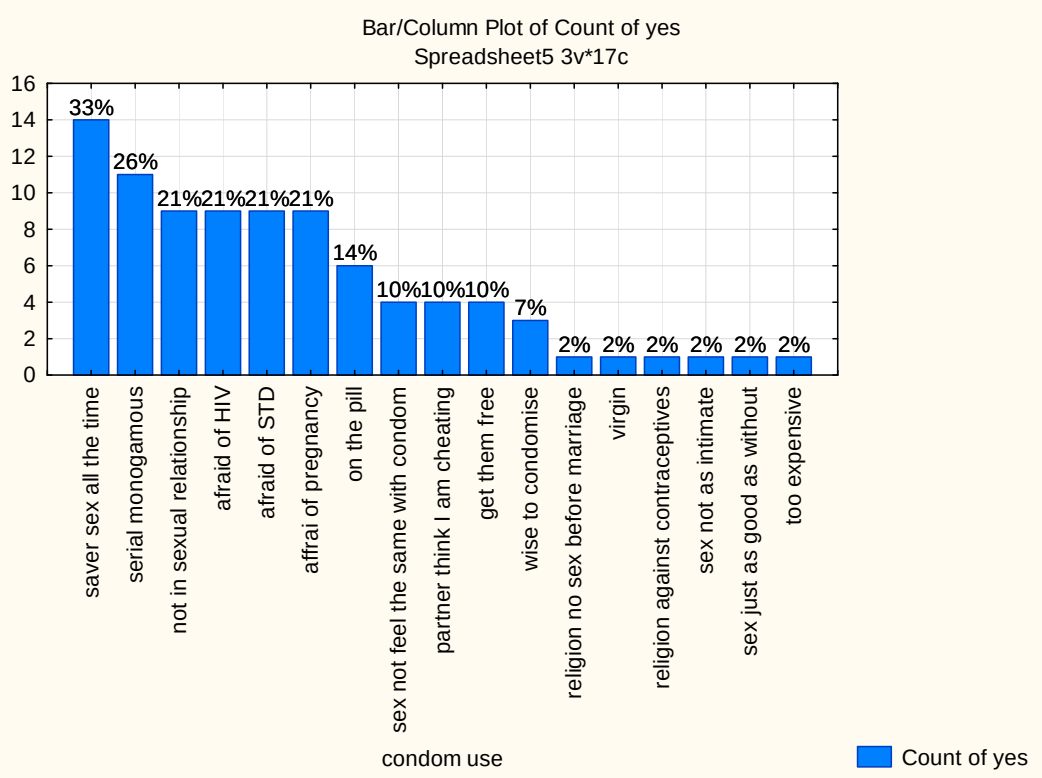
In the statistical analysis of the question “do you use a condom during sexual intercourse?” the following results were obtained: 62% (26) participants responded with the choice “no, never”. 21% (9) selected the choice “sometimes” and the remaining 17% (7) responded with the “yes, always” choice (See Figure 3.10). The results support the hypothesis that condom non-use is remarkably high. The results could then be analysed in relation to the attitudinal positions taken by the participants.

Figure 3.10: Histogram on Question; Do you use a condom during sexual intercourse?



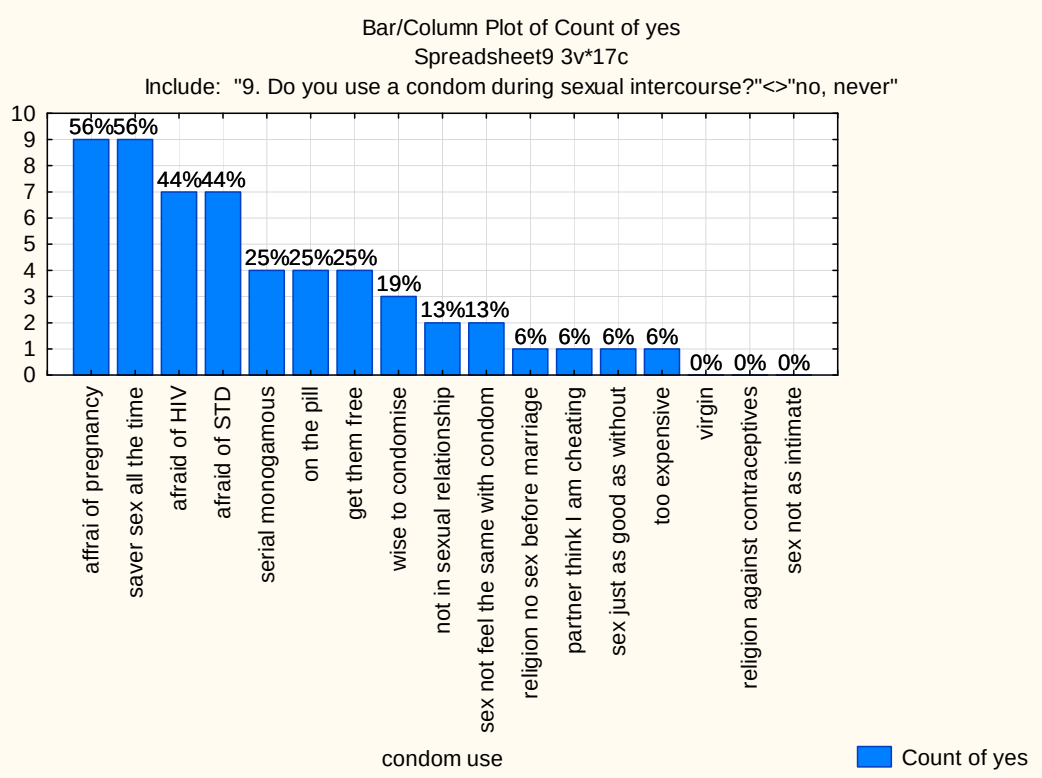
Out of the 17% of participants who claimed that they *always* use a condom, the attitudinal stances chosen to support their response was as follows: 33% of selections for the attitudinal statement 'I believe in safer sex all the time', 26% for the selections for the attitudinal stance of 'serial monogamy', 21% for the selections for the attitudinal stance of 'fear of pregnancy', 'fear of HIV' and 'fear of STI's'. 14% was for the attitudinal stance 'on the pill' and 10% or less of selections were for the attitudes of 'I am a virgin', 'sex feels the same with a condom', 'get them free, so why not', 'my religion believes in no sex before marriage', 'it is wise to condomise' (See Figure 3.11)

Figure 3.11: Column Plot on Attitudes to Condom Use – 'yes, always'



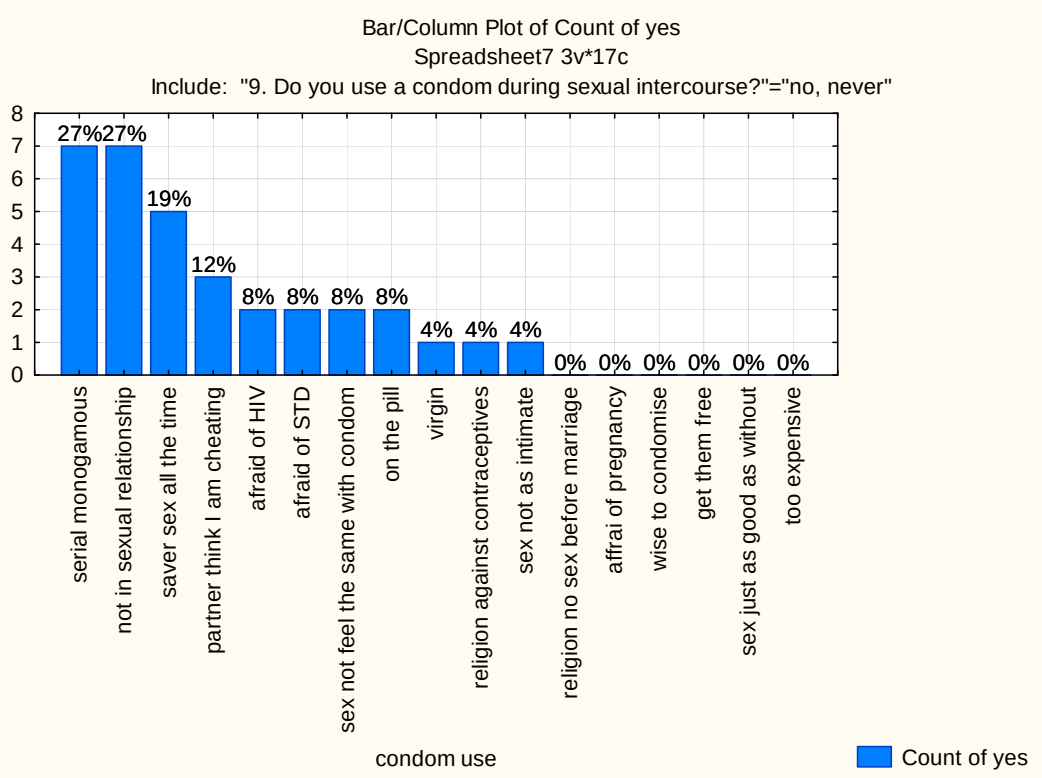
Under the exploration of inconsistent, yet occasional condoms use, participants responded with 'sometimes'. As seen in Figure 3.11, of the 21% of the participants that answered 'sometimes', the following attitudinal answers were measured: 56% selections of the attitudinal stance of 'afraid of pregnancy' and 'safer sex all the time' were recorded. 44% of selections were recorded on the 'afraid of STI' and 'afraid of HIV' attitudes and 25% of the attitudinal selections were 'serial monogamy', 'get them free, so why not' and 'on the pill'. 19% of the selections were for the 'it is wise to condomise' attitude and another 13% of selections were for the 'sex does not feel the same with a condom' and 'not in a sexual relationship at the moment'. The other selections included; 'religion doesn't allow sex before marriage', 'my partner will think that I am cheating', 'sex is just as good with a condom' and 'condoms are too expensive'.

Figure 3.12: Column Plot on Attitudes to Condom Use – 'Sometimes'



Of the 62% of the participants that reported *never* using a condom, it can be identified that the attitudinal selections that were made, are in accordance with their answer in Figure 3.13. Of the attitudinal selections, 27% were for the attitudes 'not in a sexual relationship at the moment' and 'serial monogamy'. 19% of the selections were for 'I believe in safer sex all the time', and 12% of the selections were for 'my partner will think I am cheating'. Furthermore, 8% of selections were for attitudes of 'sex does not feel the same with a condom', 'on the pill', 'afraid of HIV' and 'afraid of STI's'. Other selections of attitudinal stances towards condoms included; 'virgin', 'my religion is against contraceptives' and 'sex is not as intimate with a condom'.

Figure 3.13: Column Plot on Attitudes to Condom Use – 'No, Never'



Overall it can be concluded from the results that there were low levels of condom use amongst the participants. Furthermore, it seems that alternative safer sexual behaviours were preferred and practiced, such as, serial monogamy (faithfulness to one's partner/spouse) and abstinence.

3.3.3.3 Data Interpretation and Analysis

This empirical survey was a study to explore the attitudinal stances people might have with regard to condom use and condom non-use. Participants marked attitudinal concerns surrounding HIV, STD's and pregnancy and many more. Let's explore these in the following discussion.

Most of the voluntary participants were 30 or older; this could bare correlation to the higher selection rates of the attitudinal stance of serial monogamy. Serial monogamy accounts for the lack of condom use, as serial monogamy is also considered a safer sexual practice; if both partners are aware of their zero status (Louw, 2008: 459). Many of the participants reported to be unmarried (single), and this is of formidable concern here, as only 17% of the voluntary participants reported consistent condom use. It can

be deducted that single (unmarried) individuals are also practicing serial monogamy, but more research will be needed to support this claim entirely.

Most of the participants (88%) were female; this could be linked to the notions of gender dynamics and the agency of the female to negotiate safer sex with their partner. The correlation can be found between the non-use of condoms and the attitudinal stance of 'my partner will think I am cheating' (12% of attitudinal selections – see Figure 3.13). Being faithful to one's partner could then be correlated with gender if one considers the cultural discourses related to purity, virginity in relation to virginity testing in some cultures (Van Dyk, 2012: 460).

Most of the participants reported being from middle class, working-middle class or working class; this might have an effect on a person's ability to negotiate safer sex, should any of them be less economically liberated in their relationships. As seen in Chapter Two (see page 27) and with relevance to the amount of female participants; women are often economically dependent on men (Joubert-Wallis & Fourie, 2009: 115). This arguably, also contributes to the women's agency to negotiate safer sex in the relationship.

The majority of participants reported living in urban and sub-urban area. Notably, these areas having bigger communities and are often considered to be more secularised; a product of globalization. In urban communities, individuals arguably have more access to information about HIV and condom use, supporting the hypothesis that knowledge about the topic does not result in behaviour change – using a condom. However, one should also consider that living in bigger communities result in further exposure to more cultural discourses (global culture).

Of the group of participants who claimed to use condoms both consistently and 'sometimes', concerns surrounding HIV, STI's and most formidably, pregnancy was selected under the attitudinal selections pertaining to reasons for condom use. These attitudes could be linked to the fear associated with these phenomena, as they function in the realm of sexual immorality. One could argue that and HIV positive status, an STI or pregnancy 'exposes' one's sin of sexual immorality and could be considered as deeply 'shameful'. As discussed in Chapter Two, it is discourses of this nature that are both grounded in stigma and fuels stigmatization, discrimination and marginalization. Ulti-

mately, the fear of pregnancy for consistent condom users was the attitudinal stance most selected. This could be ascribed to the stigma related to having a child out of wedlock (bastard child). Consistent condom users also reported serial monogamy; the reported use of condoms could then possibly be attributed to pregnancy concerns.

Some of the participants reporting non-condom use ('no, never') also indicated a fear for HIV and STI's in their attitudinal selections. However, it must be noted that the main attitudinal selections relative to consistent non-condom use was; 'serial monogamy' (be faithful) and 'not in a sexual relationship at the moment' (abstinence). Both of these selections can be understood as a both a safer and sexually moral stance toward sexuality. It should also be noted that most of the participants reported being either Protestant (81%) or Catholic (12%). Within a religious approach to sexual morality, most religions preach abstinence and spousal faithfulness (serial monogamy). It could then be argued that the safer sexual practices of abstinence and spousal faithfulness are grounded in a religious framework for sexual morality. Furthermore, many religions, as identified in the attitudinal assessment under the selection 'my religion does not allow contraceptive use', do not condone contraceptive use.

To further support the findings relative to religious sexual morality, abstinence and spousal faithfulness is grounded in exegetical law; as in Exodus 20: 14: "You must not commit adultery". In contrast, condoms are grounded in an immoral, promiscuous behavioural discourse.

Furthermore, the delay of sexual debut (maintaining virginity) was selected by a few participants. These selections were very few; this could be explained by the marital status of most of the participants (36% married and 21% divorced).

3.3.4 Data Reporting

It is safe to state that the research proved to be beneficial in the understanding of condom use amongst educated medical staff. The hypothesis is then proved, as correlations between cultural attitudes and demographic criteria were identified in the study. These correlations enlightened and proved the underlying premise that knowledge about HIV and AIDS does not translate into the particular safer sexual option of condom use. However, alternate safer sexual practices were also identified in the study that functions in the realm of sexual morality; such as abstinence and serial monogamy. After correla-

tion of the findings in the empirical study, it is safe to conclude that people do in fact hold stigmatized attitudes and beliefs about condoms and that these attitudes and beliefs does in fact stem from culture, as indicated by the demographics in the study. The attitudes selected in the study to support claims of not using a condom were as follows;

a) My religion does not allow sex before marriage.
b) My partner will think I am cheating on him/her.
c) I am in a serially monogamous relationship.
d) Sex doesn't feel the same with a condom.
e) I am/my girlfriend is on the pill.
f) They are not that safe; they often break.
g) I'm still a virgin.
h) My religion is against contraceptives.
i) I am not in a sexual relationship at the moment.
j) Condoms are too expensive.
k) Sex with a condom is not as intimate as sex without a condom.
l) Condoms don't fit me/him.
m) Condoms cause infertility.
n) Condoms cause sexual diseases.

It is also safe to deduct that these attitudes affect people's willingness to engage in condom use during sexual practice. The findings also indicated that more traditional and religious behaviours had an influence on sexual practice and correlation could be drawn with the demographic findings of church doctrine. Ultimately, it is clear from the study, that having sound, medical knowledge about HIV and AIDS does not necessarily encourage people to use condoms (Working from the assumption that all the medical staff participating in the study does have sufficient knowledge on the subject of HIV and AIDS). Even though many people identified that they were afraid of STD's and HIV, their fear, in accordance with their knowledge about HIV and AIDS did not persuade them to use a condom. Stigmas about condoms were selected under the attitudinal questions from the questionnaire; which indicate that the individuals in the sample hold stigmatized beliefs about condoms. The findings in Chapter Two (literature review), and the empirical study (Chapter Three, see page 53) supports that many negative, stigmatized beliefs about condoms are grounded and founded in social entities of culture, the spiritual and religion. However, one needs to explore these broad variables in

more detail in order to determine the true magnitude and effects of these beliefs and discourses. This leads to the question; how does one go about the exploration of belief systems without offending strongly held cultural, religious and spiritual traditions? Further enquiry into the beliefs and reasons behind these identified attitudinal stances, might assist in gaining better insight in opposing the issues that contribute to stigmatized beliefs. Moreover, in the following chapters and Hermeneutical Literature Review the study hopes to determine what the best option is to move away from the stigmatized beliefs that are disempowering the existing knowledge that should be functioning as an empowerment tool in the face of HIV and AIDS.

The abovementioned might be obtained through further exploration of the grounds where stigma comes from; particularly exploration of the differing beliefs that were just identified and exploration of the social entities they are grounded in. In other words the question becomes; why do stigmatized perceptions, beliefs and attitudes about condoms exist? Thus, moving the research argument of this study towards the Interpretive task.

With the Hermeneutical Literature review, the aim is to further explore the above findings in the Descriptive-Empirical task, to understand the dynamics of the above findings and support and add significance to these findings. The Hermeneutical literature review is initiated with the Interpretive task. The Interpretive task seeks to find reasons for the findings in the Descriptive-Empirical task assisting in answering the questions above. The Interpretive task will draw on scientific theories to assist in the exploration and investigation of the findings in the Descriptive-Empirical task. In the next few chapters the study aims to explore all the above questions in the hope of gaining understanding of the dynamics fuelling the fear of HIV and AIDS, as well as the dynamics setting grounds for stigma. It also aims to explore the different ways of thinking in order to move towards de-stigmatization. But first, let's start with the Interpretive task.

3.4 LIMITATIONS

This study is not without limitations. A few restrictions to the study include the following: The truthfulness of participants, due to the fact that the survey might hold sensitive questions about sexuality that the participants might have found uncomfortable. Participants may have given socially desirable answers to the questions.

Another limitation to the study is that it did not explore specific religious discourses of practices relative to condom use. Perhaps exploration of certain religious affiliations that are linked to sexual risk and sexual morality would have been beneficial.

The limited size of the study might also prove to be a limitation; a more diverse sample might have been acquired if the sample size were increased. Most of the participants were 30 years or older and more black and other race participants would have been desirable to understand the dynamics of diversity. Furthermore, the sample group was drawn from medical staff working in the private sector medical field; thus, the participants in the study could have limited practical HIV and AIDS knowledge. In all, the sample size limited the generalizing of the findings. The sample size also restricted the amount of male participants, as the sample group had only 12% male participation. Male participants might have had different perceptions to women, which made up 88% of the sample group. As discussed in Chapter Two gender dynamics are a considerable variable under consideration in this research study as male participants might have had differing perceptions about condoms, condom use and many of the other measured variables. Provision of an Afrikaans informed consent form might have been beneficial for the Afrikaans participants, however, only English consent forms were provided.

Lastly, the study concentrated on the exploration of the stigmatization of condoms. Exploration of other possible prevention intervention could have benefitted from more attention.

CHAPTER FOUR

THE INTERPRETIVE TASK: STIGMATIZATION

The initiation of the Interpretive task also serves as the initiation of the Hermeneutical literature review. The Interpretive task will explore the research question - why do stigmatized perceptions about condoms exist? - Though theoretical interpretation and argumentation, as well as reflection from relevant perspectives.

The interpretive section of the Hermeneutical Literature Review will investigate the attitudes and beliefs people have about condoms by looking at the theoretical interpretations and different dimensions of culture and religion and how it influences the stigmatized attitudes and beliefs people hold about condoms. Moreover, the study will be exploring stigma and stigmatization as it hopes to discover why these stigmatized attitudes and beliefs surrounding condom use actually exist. One of the aims of the Interpretive task is the deep reflection about the research questions posed. After the Descriptive-Empirical task has confirmed that condoms are being stigmatized due to strongly held beliefs and attitudes that are grounded in culture, religion and tradition. The following questions can be posed: why are condoms being stigmatized? Why does stigma have such a big influence on condom use? Do the stigmas surrounding condom use actually stem from the stigmas pertaining to HIV and AIDS? How do culture, religion and spirituality really influence beliefs and attitudes? Moreover, how exactly are these beliefs truly influencing on the dynamics pertaining to stigma? Are all the cultures fuelling the same discourses and are all religions fostering the same attitudes and beliefs, or is there a distinction to be made? Do all cultures feel the same about sex and sexuality? Through thoughtful reflection on these questions, one is able to understand and respond to the particular episodes, situations and contexts one comes across. One will also be able to see the limitations of contexts and deductions, which will assist with being truthful in the findings.

The exploration of stigmatization within a Hermeneutical Literal Structure will explore the definitions of stigma, why it is exists, the parallels drawn between Stigma, Shame, Denial, Discrimination, Mis-action and Inaction, when it comes to HIV and AIDS, and the functioning of stigmatization as a social process and symbolic threat. The hope is also to explore Stigma in relation to variables of sin and sex and look at the Christian

discourses that might be contributing to stigma. Lastly, the research also aims to explore how post colonialist influence might have had an effect on stigmatization. By drawing from theories formulated by other researchers the Hermeneutical Literature review assists in exercising rational reflection and interpretation on the topic.

4.1 INTRODUCTION

Stigma refers to a social mark that singles, individuals or groups out for disgrace, humiliation, and rejection (eds. Chalcraft *et al*., 2011: 3). With relevance to this research, stigmatization then pertains to the non-use of condoms due to social marks placed on condoms that render condoms as a disgrace, humiliating and ultimately rejecting them.

The Descriptive-Empirical task proved - through both a qualitative literature review and formal, objective empirical study - the hypothesis that condoms are in fact being stigmatized due to firmly grounded belief structures and attitudes people have about condoms. It also proved that existing knowledge about HIV and AIDS did not translate into behaviour change. Furthermore, people in the empirical study turned to alternate methods of saver sex; methods that are arguably considered more 'moral' and less stigmatized than condoms (such as serial monogamy). The question regarding what is going on pertaining perception of condoms was thoroughly explored and answered. Yet, there is a certain obligation to look at the grounds for the beliefs and attitudes people hold as it was determined that they form a complicated network of interrelated frameworks that fuel the assumptions and beliefs people hold; ultimately constructing a stigmatized way of understanding HIV and AIDS in general.

Closely related to the issues of stigmatization and stereotyping are *negative attitudes toward sexuality*. Even though one would expect acceptance of HIV positive people by church, this is not necessarily the case, fear, denial and unresolved complexes mostly override compassion. As a result; negative and unexpected behaviours are often exerted by religious communities and leaders (Van Dyk, 2012: 335). This negative behaviour includes, condemnation, stigmatization, labelling of people and more.

Individuals might even be labelled as sinners or non-believes due to assumption that HIV is a disease grounded in immorality. Through this, distance (marginalization) is created between the communities and the HIV-positive individuals. HIV positive indi-

viduals are often disregarded and condemned as 'out-groups' (Van Dyk, 2012: 335). Psychologically, this physical distancing from the HIV positive person might be a means for the labeller to distance themselves as far as possible from the phenomenon of HIV. It is important for religious institutions and spiritual counsellors to actively engage in the deconstruction of stereotypes and labelling and actively avoid the practice thereof (Van Dyk, 2012: 335).

4.2 WHAT IS STIGMA?

Stigma functions over numerous domains under the HIV phenomenon. Different types of stigma exist and function differently under the dynamics of stigmatization. Let's consider these differing concepts:

- External stigma: Results in people being treated unfairly and different to others due to a certain identifiable differentiation; such as race, religion, HIV status, illness, sexual orientation etc. (Brown *et al*., 2011: 16).

- Internal stigma: Is the result of external stigma that is internalised by the person experiencing the stigma; this causes people to feel a certain way about themselves due to the external stigma they are experiencing (Brown *et al.* 2011: 16).

- Secondary stigma: Often in Africa, caregivers of people living with AIDS has led to secondary stigma; where AIDS caregivers are stigmatized and ostracised by their communities because of their work with AIDS patients (Van Dyk, 2012: 426).

Stigma however does not function in isolation. As mentioned, stigma can be understood as a product of fear, but stigma works in accordance with shame, discrimination, denial, 'misaction' (not taking the right action) and inaction (taking no action at all); with particular relevance to the HIV and AIDS epidemic.

The AIDS issue cannot be brought to a halt, if the issue of stigma is not addressed. Stigmatization of people living with HIV, as well as the stigmatization of their relatives and friends, is one of the main obstacles one is faced with in the HIV and AIDS phenomenon. To have hope of removing stigma, one has to comprehend the dynamics relative to stigma of HIV and AIDS.

From the rise of the epidemic, there have been many churches who responded in the support of HIV and AIDS sufferers. Regardless, there have been numerous responses from churches that condemned HIV positive people; declaring that HIV is the punishment of God to the wicked and immoral. Today, these proclamations of condemnation are rarer, but unfortunately existing proclamations of AIDS as a result of immorality prevail; implying that HIV is a deserved punishment resulting from sinfulness (Wangen, 2010: 424). Van Dyk explains this in the simplistic consequential understanding of reward for good behaviour, versus punishment for bad behaviour (2012: 192). Children and often people believe that people get HIV and AIDS because they have been behaving badly. Misconceptions like these contribute to the irrational fears and about HIV and AIDS and provide a powerful impetus to the development of prejudice (Van Dyk, 2012: 192).

Stigma has been largely grounded in the religious framework of sin; as HIV and AIDS is related to the understanding of sin and of human sexuality. Wangen states that: “In people’s minds sex is linked to sin and sin to sex” (2010: 424). This is one of the reasons why HIV and AIDS is such a profoundly stigmatized phenomenon. It can then be deducted, that at work in the process of stigmatization is the ‘unholy trinity’; namely, AIDS, sin and sex. In a triangular process these reinforce one another; in turn reinforcing stigma.

4.3 DENIAL AND STIGMATIZATION

As argued above, stigma is undoubtedly a product of fear of the unknown phenomenon of the HI-virus. Stigma, Shame, Discrimination, Denial, ‘Inaction’ and ‘Misaction’ (SSDDIM), as intricately linked parts, are symptoms that undeniably contribute to this fear (eds. Chalcraft *et al*., 2011: 3). Gugu Dlhamini was stoned to death by her neighbours due to fear encompassed by these factors. Her death clarifies that an HIV positive status is a burden of carrying a terrible secret (Balcomb, 2006: 112). For Gugu Dlhamini the disclosure of her HIV status was a death threat; for others similar disclosure often results in the social death due to stigma, shame and discrimination. This proves that the stigma attached to the disease is remarkably overwhelming.

Linked to stigma is the socio-psychology of dirt and pollution; as the people living with HIV and AIDS are seen as polluted and contaminated by some invisible dangerous

force (Balcomb, 2006: 113). Thus, stigma can be linked to African spirituality and African Christianity; as sickness is seen as a form of pollution and contamination that needs cleansing. For example, Mr Nelson Mandela was considered 'contaminated' after he spent time with HIV and AIDS orphans; such is the power of stigma surrounding HIV and AIDS (Balcomb, 2006: 113). The African spiritual view of contamination can often be viewed as 'Misaction' (product of fear of the disease), but spiritual healing in African spirituality plays a fundamental role in the healing process of the individual and the relationships in the community, and should therefore not be denounced or ignored.

Due to the notions of 'contamination', it can be argued that this idea of dirt and pollution has spilled over into the utilising of prevention interventions in communities. In this view, condoms could be viewed as a contamination or pollution of the sacred sexual act. Moreover, condoms could also be viewed as a means of hiding one's contamination or pollution (sickness) from one's partner (Balcomb, 2006: 113).

It accordance with the above, it is safe to state that; in light of the realities of stigma, HIV and AIDS is as much a socially constructed disease as it is caused by the virus. Medical science should collaborate with the social sciences to develop a means to deconstruct the stigma, shame, denial, discrimination, inaction and 'misaction' as products of fear. Though, one is also confronted with theological challenges. Balcomb formulates these theological challenges as (a) the dehumanization of the stigmatized person in the realm of human dignity, (b) the issues pertaining to social jealousy, mistrust and economic inequality, and lastly, (c) the issues of social pollution, cleanliness and dirt. According to Balcomb, these theological issues function in the realm of denialism; parallel to the HI-vius (2006: 113).

Although stigma is recognised as a fundamental concern in the HIV and AIDS epidemic, Wangen argues that the distinctive definition of stigmatization seems unclear (2010: 426). This could be ascribed to the fact that stigma is understood as a complex social phenomenon; thus, some researchers claim that stigma is context specific. In contradiction, other researchers claim that there are similarities in the causes of stigma across different contexts (Wangen, 2010: 426).

4.4 STIGMATIZATION AS A SOCIAL PROCESS

Goffman formulates that the stigmatized person is regarded as 'not quite human' (1981: 15). This links with the denouncing of the stigmatized individual's human dignity. For Goffman, the stigmatized person is understood in terms of discrediting attributes and therefore the person's social identity is spoilt. UNAIDS defines stigma as the 'devaluation' of a human being (2002: 15).

There is another angle from which one can understand the phenomenon of stigmatization; through the exploration of the process of stigma itself. Deacan, Stephney and Prosalendis explain that stigma is a "complex social process that is linked to competition for resources and tied into existing mechanisms of exclusion and dominance" (2005: 25). Furthermore, there is an identifiable connection between stigma, prejudice and social inequality; existing stereotypes and prejudices, as well as power alliances often enforce stigma, racism, sexism and homophobia. This can be understood as 'multiple', 'double' or even 'triple' stigmatization (Wangen, 2010: 427).

It is known that terminal diseases and sexually transmitted illnesses often carry stigma. Stigma does not necessarily link all people with the disease to immoral sexual behaviours, but the disease's stigmatization suggests that already defined groups are considered responsible for the severity of the disease (Wangen, 2010: 427). The stigma of HIV and AIDS is linked to other forms of prejudice, such as racism, gender and sexual promiscuity. For example, women are more likely to be stigmatized than men, due to social discourses surrounding the sexuality of women (see Chapter Two). It is then safe to deduct that stigmatization is linked to social order and hierarchy. This supports the notion that stigma is culturally constituted in lies within the realm of cultural discourse. Thus, supporting the statements and deductions made in the Descriptive-Empirical task. Ultimately, stigmatization is a social process dependent on social power; it is therefore upheld by and entrenched in economic, political, educational, cultural and social institutions (Wangen, 2010: 428).

4.5 STIGMATIZATION AS A SYMBOLIC THREAT

The failure to abide by the norms and values of society often results in stigmatization. This links with the discussion in the previous chapter, as there is a distinct intersection

between HIV related stigmatization and the norms and values of society. Under an African perspectives; stigma is a result of shaming the community and disrupting the balance between the relationships in the community, where in a Christian paradigm, it is linked to sexual promiscuity and sinful behaviour. The fundamental, underlying human emotion correlating with stigma is the perception of threat (Wangen, 2010: 429).

Stigma could also be understood as humanity's way of organising experience; illness such as HIV is perceived as a threat to the other and not to the self. Kgalemang states that; "Stigma is a product of the human need to bestow meaning upon experience; it provides individuals with an ordered sense of the world around them…" (2004: 149). This need to order is a general condition of human life; needed to make sense of the social world. This organisational thinking spills over into the understanding of Sin and Stigmatization. For example; AIDS is a punishment of God, therefore a HIV positive person must have sinned. However, simplistic these deductions, they function from an intrinsic condition of humanity.

4.6 SIN AND STIGMATIZATION

Churches need to be aware of the social discourses they communicate. Furthermore, churches need to be aware of stigmatization as a tool in the production of social order. Gillian Patterson writes:

> … Religious institutions are able, with a clear conscience, to stigmatize and exclude members who are discovered to have 'sinned': they are doing so, they believe, on the grounds that fear of exclusion is necessary for the preservation of their institutional identity and the protection of the moral welfare of the majority of their members. (2005: 5).

Religious communities therefore exert power over their members, just as social and political structures tend to (Wangen, 2010: 430). Let's now consider the different discourses projected by the church that ultimately fuels stigma.

4.6.1 Christian Discourses on HIV and AIDS

Since the identification of the virus in the early 80's, many Christians responded in three identifiable ways: Firstly, as noted previously, it was thought that HIV and AIDS was God's punishment for unnatural sexual behaviour amongst homosexuality. This re-

sponse could have been prompted by the fact that the virus and the syndrome was firstly identified in homosexual men, and was originally named GRID (Gay Related Immune Deficiency) (Chepkwoney, n.d. :56). This response has created many ethical dilemmas in light of the scientific paradigm of the virus. These dilemmas are as follows:

- Interpretations such as these have led to deductions and assumptions that all HIV and AIDS sufferers are homosexual. Moreover, that all homosexuals are HIV positive, promiscuous and outright immoral (Chepkwoney, n.d. :56). These are projections of perceptive classification that fuel stigma.

- Another dilemma arises; how does one explain the rapid spread of the virus through heterosexual relationships? Particularly in Africa. Homosexuality is assumed not a common practice in Africa; as Africans regard this practice as taboo (Chepkwoney, n.d. :56).

The second response of Christians was that HIV and AIDS is not only a punishment for homosexual immorality, but for human immorality too. This deduction was derived from the scientific discovery that the virus spreads amongst intravenous drug users as well as heterosexual behaviour; consequently, ascribing its prevalence to sexual immoralities and promiscuity (Chepkwoney, n.d.: 56). The God-Image is projected here that God is punishing humanity for their sins. If this is true, then Christianity has the very difficult challenge of explaining why the good God would punish children and moral people with the immoral HI-virus; let's consider the following examples:

- Why would God punish morally upright people, who serve him, who contract the virus by no fault of their own (For example, rape or blood transfusion).

- Why are so many children being born HIV positive from HIV positive mothers? Who is the sinner and who is the victim in this case?

- Why would the good Lord punish a faithful spouse, who contracts the virus within the institution of marriage?

- How does one explain the punishment of God, when caregivers and health workers accidently contract the virus through caring for HIV positive patients? Does it truly

matter how one acquires HIV? Do different measures of acquisition of the virus exclude a person from stigma and discrimination?

- How does one explain the ethical dilemma of how promiscuous and 'immoral' people who go scourge free (do not become HIV positive) despite their promiscuity? In other words, why do some sexually active people become HIV positive and others do not?

These are all puzzling questions, but they are fundamentally grounded in the Image of a punishing God (Chepkwoney, n.d.: 57). The implication of such a view is the deduction that all HIV positive individuals are in fact sinners, if God punishes sinners with illness (Chepkwoney, n.d.: 56).

It is then safe to state that deductions such as these are very dangerous; it lies in the fact that interpretations as those above create negative responses that are contrary to Christian ethics towards human acts. Christian ethics from a pastoral approach to Stigmatization will be elaborated on in chapter six. The dangers can be identified as followed:

- In the initial reaction of believing that HIV and AIDS is a punishment for sinners, is fundamentally adopting a judgemental attitude towards HIV and AIDS sufferers. The general feeling amongst those who judge is that HIV and AIDS people brought it on themselves. "Since God is punishing them, there is little that can be done." (Chepkwoney, n.d.: 58). Some Christian pastors have openly refused sympathy for HIV positive individuals; as they brought it upon themselves. Other Christian pastors have refused to marry individuals, until they certify their HIV negative status (Chepkwoney, n.d.: 58).

- The other danger is that the picture of an irrational God is displayed. God id represented as cruel, and unforgiving; a God who fails to identify the real culprits and punishes the innocent (Chepkwoney, n.d.: 58). This seems contrary to the biblical teaching of the loving God that sent His only Son to die for our sins.

- Another danger is the emergence of self-styled Christian healers that proclaim that God is behind HIV and AIDS. Satisfied with the notion that HIV is a punishment for sin, healers proclaim that they can cure the HI-virus. Consequently, HIV posi-

tive people and AIDS sufferers are being exploited and get given false hopes (Chepkwoney, n.d.: 58).

- Lastly, due to the Christian discourses of condemnation of sinners with HIV, African people turn to African healers for traditional remedies (Chepkwoney, n.d.: 58).

In accordance with the above, it is safe to state that social and cultural margins are created which oppressed persons and communities are conditioned into. This might contribute to the perception of certain people as 'the other' (Wangen, 2010: 431).

Social sin-talk is prone to stigmatization and marginalization because one 'falls into the trap' of internalising discourses and ultimately using stereotypical language. Consequently, the human beings who are stereotyped are denied their full humanity (Wangen, 2010: 432). One is often unaware of how one's sin-talk is part of the social discourse that results in marginalization.

Essentially, stigmatization might then be understood as a social process in which people living with HIV and AIDS are denied their full human dignity; due to their perceived state of immorality and sinfulness. The perceptions of immorality and sinfulness have been transformed into markers of moral defilement and difference (Wangen, 2010: 432). Stigmatizing HIV positive human beings renders them less representative of the Image of God, because of their 'sinful' nature. Under this thinking, sin is equated with immorality. HIV positive people are then considered essentially different from the people who are not living with the HI-virus; thus, also lessens the bearers of *Imago Dei* (Wangen, 2010: 432).

Sin, is key to the understanding of the Christian message of salvation, as it is sin that separates human beings from God. However, it must be noted that the notion of sin cannot be used as an indicator of essential difference amongst human beings. Unfortunately, this is what is happening in the realm of stigmatization. Human beings are all sinner, even before one has sinned – sin cannot be avoided. All human beings are unable to live according to the Law of God (Wangen, 2010: 432). Sin is therefore ubiquitous.

Because stigma is embedded in exiting inequalities such as racism, gender inequalities, poverty and more, it become impossible to understand stigma as an a prejudicial prob-

lem of the individual; rather, stigmatization should be addressed as a social and structural problem. Individuals are caught in the structures of sin, whist being the force behind the structures; consequently, humanity becomes enslaved by humanity's own structures (Wangen, 2012: 434).

Stigma keeps people living with HIV and AIDS trapped in structures of oppression, stigmatization and discrimination, as they are often marginalised by societies and their communities because of their HIV positive status; this marginalization, discrimination or stigmatization itself is an expression of sin. Liberation theology allows one to address the notion of stigma; due to the harmful consequences it has on human dignity. Christians should, in liberation theology, confront the enslaving power of the stigma related to HIV and AIDS (Wangen, 2010: 435). All humans were created in the image of God (Imago Dei) and stigmatization is fundamentally a denial of that ontology. Stigmatization is then a projection of sin in itself.

4.7 SEX AND STIGMATIZATION

As touched on earlier, people who live with HIV are stigmatized against and marginalised because of the belief that one has *sinned sexually*. In order to understand the dynamics linked stigma in the realm of sexual immorality, one needs to explore the link between sexuality and sin.

4.7.1 Sin, Sex and Taboos

It is not only in the Christian religion that there has been an ambivalent understanding of human sexuality. The theme has been prevalent in the science of religion for many years. Douglas argues that religious rituals frame experience. Rituals of impurity and purity create representational guidelines that are publically expressed. These experiences are organised into different categories, the contradicting experiences that do not coincide with these categories are perceived as dirty, polluted or impure and ultimately unacceptable (Wangen, 2010: 436). Under the category of holiness is 'wholeness' and 'completeness'. To be holy, is perceived as being 'complete'. Holiness in the realm of human behaviour is acting in a consistent manner and with integrity. Women tend to be more identified impure states than men; linking with notions of gender inequality. This mirrors designs of hierarchy on the larger social scale (Wangen, 2010: 436).

Ricoeur argues that understandings of sin and defilement are intricately linked; the notions of guilt, sin and defilement functions in the realm of moral evil (1967: 29). Essentially, guilt is the subjective experience of moral evil. It is understood that sin disrupts humanity's relationship with God, and because this relationship also has the form of the covenant, which includes one's relationship with thy neighbour; therefore human relationships are also included (Wangen, 2010: 436). Experiences of defilement often functions under the perceptions of being dirty or stained. Furthermore, this experience of defilement is undoubtedly linked to the sexual sphere.

Sexuality is regarded as impure if it happens outside the boundaries of marriage. Ricoeur describes marriage as an avenue for purification; being 'redeemed' from one's impure state through the observance and respect for the institution of marriage (1967: 29). Sexual contamination is then fundamentally concerned with purity and virginity ('spotlessness'); as opposed to sexuality and contamination (Wangen, 2010: 438). To avoid defilement, one has to maintain a virgin/'spotless' state of existence.

Virginity[6] therefore functions within the paradigm of purity; however, the definition of a virgin is somewhat blurred in its contemporary formulations. This considered, the question must be asked; what is the definition of virginity? Is virginity defined by the female hymen being intact? If so, what definition is ascribed to male virginity? Is 'sexual debut' an adequate definition for virginity? If women or girls have experimented with sexual behaviours that do not include vaginal penetration, is she still considered a virgin, or has she been 'defiled'? (Brown *et al.*, 2011: 43). Often, the answers to questions such as these are grounded in cultural and religious discourses of purity and defilement. Notions of sin, defilement and impurity is often used as a social tool of demarcation; the 'pure' and the 'impure' (Wangen, 2010: 438). Therefore, there is no longer a shift from the inescapable classification, no purification rituals; people in communities become conditioned into these referential classifications.

What becomes of prevention strategies when implemented into this social context? In the context of purity discussed above, advocating abstinence before marriage and faithfulness in marriage are the two favoured and idealised prevention strategies. In an ideal,

[6] Virginity's synonym is purity, as with the metaphor of olive oil; if olive oil is not blended with any other oil, it can be sold as 'extra virgin olive oil'. This implicates that a definition of a virgin is sexual purity, if they have no sexual contact or knowledge about sexual activity, they are in a pure state of virginity (Brown *et al.* 2011: 43).

mythical world where choice and agency are never limited, where sex is never forced and in an ideal world where women never need to use their bodies for currency; in a world like this prevention strategies like abstinence and faithfulness seem ideally appropriate. In this mythical world, virginity and secondary virginity seem attainable. In an ideal world where no war, forced migration, poverty and rape do not exist; faithfulness and abstinence are perfect prevention interventions against HIV (Browning, 2009: 30). Sadly, this ideal, mythical world is non-existent and has not even been attained in the most overdeveloped countries in the world.

4.7.2 Idealising Prevention Measures

HIV is a sexually transmitted disease, yet it could be viewed in a less discerning light if sex and sexuality is viewed as a vehicle for the transmission of the virus, rather than the cause of the epidemic itself. This links with the statement that HIV is a socially constructed disease. Despite the complexity of factors in society and dynamics influencing the epidemic; prevention strategies start and end with sex (Browning, 2009: 31).

Under the prevention strategies made available, abstinence seemed the intervention most opted for amongst Churches and religious organisations, as abstinence is grounded in sexual ethics and morality too. Some advocate that abstinence is an unrealistic ideal and advocate for wider condom distribution campaigns (Browning, 2009: 31). Ironically, neither abstinence nor condoms provide true, safe sex. Furthermore, the debate over their promotion can obscure the true issues relative to the epidemic (Browning, 2009: 31).

By focusing on ideal prevention interventions one fails to pay attention to factors such as poverty, gender inequality and political instability which contribute to the risks that are expressed and compensated for by the sexed body. Browning states that; “the debate over abstinence versus condoms confines the solutions to sex without seeking to understand the sexualities and their intersections with culture, race and class”, and ultimately human dignity and identity (2009: 31). Not considering these relevant factors could be a contributing factor to the stigmatization of condom use, as condoms are not presented in a contextually relevant manner.

Browning argues that the ABC intervention model is limited to abstinence as prevention, possibly due to its moral weight (2009: 31). Nonetheless, Browning argues that

abstinence does not provide one with a simple solution and it does not actually stipulate a moral imperative. Therefore, abstinence can be considered as moral or immoral, depending on the way it is communicated (Browning, 2009: 31). For example, if abstinence is communicated in a realm of anxiety namely, acting morally because of anxiety of possible consequence is immoral in itself, as it robs sex from intimacy and tenderness (Louw, 2008: 366-367). To elaborate, abstinence is considered moral if it saves life and prevents HIV and AIDS and ultimately serves love. However, abstinence as immorality destroys life; when abstinence is understood primarily in terms of purity and pollution it increases stigma, and serves as an obstacle to HIV testing and status disclosure and facilitates the spread of the disease.

In response to the consequences of the idealised prevention interventions, Browning poses that employment of a critique on postcolonial influences on abstinence should be advocated to redefine and reconstruct the socially communicated ideas of abstinence in the current African setting (2009: 32). This redefinition will result in abstinence being presented as a 'space' that will contribute to human flourishing, as opposed to a 'prohibition' (Browning, 2009: 33). Abstinence as morality is often tied to taboos and sin in African spirituality and cultural practices. This has often leaded to the implementation of cultural practices to enforce this morale. For example, the cultural practice of virginity testing. Some of these cultural practices enforced by notion of morality have consequences if the taboos are broken – such as death or exile).

The distinction should be made between abstinence and prevention and abstinence as morality. In contrast to abstinence as morality, as discussed above, the goal of abstinence as prevention allows abstinence to function as a means to decrease HIV infection. In contradiction, most studies have shown that abstinence is not successful in preventing teen pregnancy; as those who pledge abstinence within a religious dimension often do not take precautions if someone decides to break their commitment (Browning, 2009: 34). It is therefore naïve to believe that abstinence is always an option, and it is therefore naïve to believe that it always works.

The conception that abstinence is an individual choice, much like the choice of using a condom, becomes slightly less clear. Decisions individuals make must be accepted and respected by others. Should someone who chooses abstinence or consistent condom use have sex forced on them, their choice has been denied and denounced – as has their

human dignity. Ultimately, abstinence and condom use becomes an impossibility in a world where women are disempowered and do not have agency over their decisions and bodies (Browning, 2009: 35). Note here that the failings of abstinence do not enable the argument of condoms, as condoms have their limitations with regards to safe sex. Even though condoms are considered one of the best barriers to the transference of fluids, it is incompatible with the African dialectic of life as the thesis. It is argued that condoms are a western intervention that has been brought to Africa. Browning states that; "they carry with them the stigma of disease because they have been primarily used to prevent AIDS" (2009: 35). Like abstinence, condoms provide little room for equal negotiation. Furthermore, condoms do not protect married couples as they are rarely used in the realm of faithfulness, and the pressure of having children prevents consistent condom use even amongst HIV positive couples. This leads to re-infection and increases in viral load.

If abstinence and condoms are not a guarantee for safe sex, then why are churches and governments opting for these two preventions as optimal prevention interventions against HIV transmission? Many of these prevention programmes come from the West, so why have they not been translated to an African context?

By looking at abstinence and condoms through the lens of a critique of postcolonial influences and effects on colonised countries, one might be able to comprehend and even deconstruct the assumptions present in the shared history as colonizers and the colonized.

4.7.3 Critique on Post-Colonialism as Influence on Stigmatization

The first critique on postcolonial consequences influencing on stigma is the critique of the ABC model of prevention. The ABC model was presented to Africa in a language that can be named as paternalistic; this type of language often congers up of the times of colonialism (Browning, 2009: 37). By presenting the message of ABC as being as simple as the alphabet, it reduces the prevention strategy to be simple and often not taken seriously. This simplification of the prevention methods might also give rise to stigma; if preventing HIV is so simple, then those who have contracted the virus cannot be very smart (they don't even know their ABC's).

Another critique on post-colonialism can be identified in the presentation of the ABC campaign as a prevention strategy in Africa; the ABC campaign is presented in the assumption of the English language; the language of the colonizer or the West is again being used in attempt to shame the behaviour of the people in African (Browning, 2009: 37). The following questions then arise; how does the ABC campaign function in countries such as Ethiopia that do not use the Latin alphabet? How does the ABC campaign in the English language function in the African context where there is primarily verbal communication and the written English language is not known?

One of the things that contributed to the stigma of the phenomenon of the HI-Virus was naming the phenomenon correctly. For instance, AIDS was initially named GRID (Gay Related Immune Deficiency) when it was first identified (Schmid, 2006: 94-95). This contributed directly to the stigmatized notion that HIV and AIDS is only a 'gay' disease. Evidently, this is not true. With the history of colonially emerged definitions for AIDS like *A*merican *I*nvention to *D*iscourage *S*ex; these definitions encouraged certain beliefs about HIV and AIDS and contributes to the stigmatization. This definition could also be ascribed to the history of colonialism. As cited in Browning, Dube states that one of the main problems with AIDS is that it is not understood, because no name has been giving to it in Africa; it has to be correctly understood for effective strategies to be developed for it (2009: 37). Similarly the ABC strategy is unknown and therefore not understood or utilized. Exploration of the parallel problems between the ABC approach and Traditional Christian Sexual Ethics and Morality might be beneficial here to gain further insight into the implementation of abstinence and faithfulness and prevention measures in the realm of stigmatization.

4.7.4 ABC Approach and Traditional Christian Sexual Morality

As identified previously, people living with HIV and AIDS are considered sinners in some Christian views towards sexual morality, because HIV positive people did not 'abide by the rules' of some quantified Christian norms surrounding sexual morality (Wangen, 2010: 443). Again, the notion is identified that an HIV positive status can be attributed to the punishment of God upon the immorality of humanity.

In the traditional approach to Christian sexual moral norms, the notions of abstinence (A) and being faithful (B), under the ABC approach, are most likely to correlate. The approach formulates the following:

- A - Abstain from sex until you get married
- B – Be faithful to your spouse when you do get married
- C – If you are unable to abstain or be faithful you should use a condom

Rationally, the plan has considerable substance, but in practice it has considerable limitations. Wangen argues that it is limiting since it focuses on the sexual behaviour of the individual. This is not only inadequate in the prevention of HIV and AIDS, but it might contribute the very factors that enable the spread of the virus (2012: 444).

With the central focus on individual sexual behaviour the ABC approach reinforces that the virus is sexually transmitted, ultimately intensifying the stigma and perceptions that contribute to an incorrect perception of the disease itself. Fundamentally, the approach does not recognise that there are multiple influencing factors that might impact the individual's ability to use the ABC approach (Wangen, 2010: 444). For example, some women might not have the agency in a relationship to negotiate safer sex, or some people might find themselves living too far from clinics and might therefore not be able to attain condoms. It must therefore be realised and recognised that certain changes in individual decisions will only be actualised once the key environmental and contextual changes are realised (Wangen, 2010: 444). In other words, changes in the social contexts are needed before changes in the individual will happen. To change the social context one must start with the deconstruction of social norms and perceptions that constitute and instigate stigma. It must be noted that complete change is not attainable in all contexts (Wangen, 2010: 444).

Abstinence, faithfulness and condom use can also be linked to gender inequalities and should be considered relevant under the discussion of stigma.

In many cultures it is believed that a married woman's body no longer belongs to her once she enters marriage. With affect, some women have no power over sexual negotiation, regardless of her husband's HIV positive status or faithfulness. UNAIDS elabo-

rates by spelling out the problem: “Both women and girls report increased violence at the hands of their partners for requesting condom use, accessing voluntary testing and counselling, refusing sex within or outside a marriage or testing HIV positive” (UN-AIDS, 2002: 10).

The prevention of condoms is an unremitting issue, as some Christian aid organisations promote abstinence and faithfulness and other proclaim that the failure to promote condoms is a state of denial that increases the death toll (Wangen, 2012: 445). But it is undoubtedly clear that condoms are being stigmatized due to strongly grounded traditional cultural contexts and Christian doctrines surrounding sexual morality. Condoms may not be the solution, if one considers the dynamics of gender inequality. If women lack the power to negotiate abstinence, there is a good chance that she will lack the power to negotiate condom use. It is therefore safe to say that prevention strategies should not solely be focused on the promotion of individual sexual behaviour change through abstinence and condom use, since the problem lies much deeper (Wangen, 2010: 445).

More research is needed with regards to the power of women in the sexual relationship. Illiteracy also contributes to the problem, as inadequate education is supplied to women about sex and sexuality. This could be attributed to the notion that ignorance about sexuality is a sign of purity and innocence (Wangen, 2010: 445). Virginity is linked to this ignorance about sexuality due to the fact that women do not want to be judged when seeking the relevant information surrounding sexuality. Fear that one might be viewed as impure or promiscuous. Thus, the enforcement of another stigmatized belief and attitudes. Yet, a virgin status has also been proven a risk for higher vulnerability to rape: this could be considered a result of the myth that sex with a virgin might cure one’s HIV and AIDS (Wangen, 2010: 445). In contradiction to the previous, the latter presents another stigmatized belief that proves to be harmful to virgins.

After careful consideration of the above, it is then safe to deduct that for women in Africa, the ABC approach is inadequate and offers very little protection for women from HIV infection. The beliefs and attitudes enforced by the ABC approach’s discourses reenforce the stigma about HIV and AIDS.

Another problem with the ABC approach is the underlying focus on ideal behaviour (Abstinence) and the descending scale of morality/acceptability.

Chalcraft explains:

> What the approach seems to say is: **A**bstain, since no sex is the best sex; or if you can't abstain, then at least **B**e faithful; if you refuse to be faithful then at least have the decency to use a **C**ondom. In some countries the letter **D** for **D**ie has been added, as the approach is not encouraging saver sexual practices, but instead it is driving the topic of sex under the ground (eds. Chalcraft *et al*, 2011: 15).

In this understanding, the ABC approach tends to represent not only a focus on ideals, but it suggests that condom use is an expression of sexual immorality and a stance of 'common decency' when you are promiscuous. Thus, condoms are only for those who are 'unable to do the right thing' (Wangen, 2010: 446). Not utilising prevention methods results in the further spread of the virus, which in turn reinforces stigma and so the cycle continues.

Traditionally, Christian sexual ethics have been too absorbed with the ideals of sexual ethics. The fear exists that welcoming people into the church as they are (HIV positive), without pointing to their 'sin', will render the church as a place where sin is harvested and accepted (Wangen, 2010: 447). Coinciding with the view that the church is a holy place, this could result in a construed view of the church, as the church resembles the body of Christ; the ecclesial identity of the church then becomes distorted (Louw, 2008: 424). The holiness of Christ's body could not be HIV positive. The fear of moral contamination lingers in the church and prevents the church from ministering to HIV positive people and allowing HIV positive individuals in the church. HIV positive people might be identified as sinners. Jesus Himself did the opposite: He ministered to the sufferers and the sinners, He died for the sinners (Wangen, 2010: 447).

The way in which one talks about sin might be a tool for exclusion in itself, particularly to those who already find themselves on the margins of society (like people living with HIV and AIDS). Ultimately and most importantly, stigmatization in itself could be considered an expression of sin, depending on what is meant by sin. In this respect, stigmatization is considered sin because it can be seen as a denial of the Imago Dei (Image of God) in people who are living with HIV and AIDS. In other words; stigmatization is a denial of God's image - the Image in which man was created. The behaviour of stigmatizing the other can then be considered sin, especially when humanity is called to re-

semble and represent God (Wangen, 2010: 447). In this view, stigmatizing the other that might have 'sinned' is sin. Sin also expresses itself in social and global injustice, gender inequalities and structures of oppression and domination (Wangen, 2010: 447).

4.8 CONCLUSION

In this chapter it is clear that stigmatization ultimately affects people's belief systems rather profoundly. It was also determined in the Descriptive-Empirical task that beliefs about sexuality fundamentally add to the stigma and stigmatization of HIV and AIDS and sexuality. Beliefs and understandings society holds about sexuality contribute to the magnitude of stigma surrounding the HIV epidemic. It was determined that the issues relative to HIV and AIDS cannot be brought to a halt if the issue of stigma is not addressed. In order to move away from stigma, one needs to fully comprehend the dynamics relative to the stigma of HIV. These include the churches response to the epidemic, the societal perceptions of sexuality and sexual morality and the effects of post colonialism in response to the virus.

Through theoretical reflection, it was determined that sin was linked to sex and vice versa and that this view enforces stigma about HIV and AIDS and stigma about sex and sexuality (Wangen, 2010: 424). The Interpretive task further investigated that stigma is also a product of the unknown of the HI-Virus as well as the unclear definition of stigma: claiming that stigma is context specific but has similarities over numerous contexts (Wangen, 2010: 426).

In this chapter the stigmatized person's human dignity being denounced was also discussed. Stigma spoils a person's identity. The stigmatization of HIV and AIDS spills over into other forms of prejudice: such as sexism, racism, and sexual promiscuity (Wangen, 2010: 427). It was also discussed that stigma could be understood as humanity's way of organising experiences in life and bestow meaning on experiences (Wangen, 2010: 429).

The Interpretive task explored the discourse that HIV and AIDS is God's punishment for sinfulness like homosexuality and human immorality are mere deductions of generalised scientific discoveries – such as HIV prevalence rates amongst homosexual men. In all, these discourses and deductions are grounded in the view that the good God is a

punishing God. The implication of such a view is that all HIV positive individuals could be viewed as sinners. The Interpretive task therefore enlightens the Christian discourses projected by the church that instigates stigma.

This chapter also spoke about the ABC intervention model. Although the model advocates three things as prevention (abstinence, being faithful and condom use), the actual focus is on the "A", abstinence as the ultimate prevention. Browning argues that abstinence does not provide a solution and it does not actually give any moral imperative, as abstinence can be moral or immoral depending on the way it is communicated (2009: 31). Abstinence as immorality ultimately destroys life and increases stigma if it is primarily understood in terms of purity and pollution.

Also discussed in this chapter was the central focus on individual sexual behaviour the ABC approach reinforces that the virus is sexually transmitted, fuelling the stigma and perceptions again. Wangen explains that the ABC approach does not recognise that there are multiple influencing factors that might impact the individual's ability to use that ABC approach as their individual prevention model (2010:444). The ABC model contributes to the stigmatization of condom use and HIV, as Condom use is for those individuals who are 'unable to do the right thing' (Abstain of be faithful).

The Descriptive-Empirical task succeeds in answering the question of what was going on, and determined that condoms were being stigmatized due to attitudes, beliefs and perceptions contributing to stigma. The investigation under the Descriptive-Empirical task explained that condoms were therefore not being used. It further proved that educational intervention is not enough to move towards a de-stigmatized mind-set. The Interpretive task supported this in its investigation of the question why do stigmatized ideas about condoms exist? The Interpretive task concludes that stigmatised beliefs about HIV and AIDS and condoms as a preventative intervention is vast and explains the challenges that need to be addressed in order to move to a de-stigmatized thinking. This flows to the next part of the Hermeneutical Literature review and exploration of the question: what ought to be going on? In the second part of the hermeneutical literature review the Normative task will commence. The Normative task will seek to reflect ethically on the findings from the Interpretive task through the consultation of theological interpretation, human sciences and good practice by looking at healthy ways to view human sexuality, the human body and sexuality as well as a Christian spiritual ap-

proach to sexual ethics, as formulated by Daniel Louw. Furthermore, the Normative task will look at Louw's theory on marriage and sexuality and the we-space.

CHAPTER FIVE:

THE NORMATIVE TASK: HUMAN SEXUALITY WITHIN THE FRAMEWORK OF A CHRISTIAN SPIRITUAL PARADIGM:

With relevance to this study, the Normative task aims to seek God's will for the present reality of the stigmatization of condoms. In other words, throughout the Normative task the aim is to explore what God's will is surrounding condom use, HIV and AIDS and sex and sexuality (Osmer, 2008: 135-137).

In the previous chapter, the Interpretive task determined that stigma about HIV and AIDS was influenced by cultural and religious views on sex and sexuality. Thus, the present understandings and practices surrounding the stigma of HIV and AIDS and condom use are filled with values and norms. The Normative task will seek to develop ethical principles to channel stigmatization towards moral ends. Ultimately, the Normative task will interpret the present episodes of what is going on with regards to the stigmatization of condom use by employing theological concepts and reforming these present actions through deriving norms form good practice. In other words, the Normative task seeks to analyse present examples and transform these examples into good practices to generate new understandings of sex, sexuality, stigma, condom use and HIV and AIDS; all in an attempt to move towards answering the question; what ought to be the understanding and perceptions of condoms?

In an attempt to answer this question, the chapter shall start off with an exploration into sexual ethics and the view of human sexuality. As determined in the previous chapter, most of the pathology of stigma surrounding HIV and AIDS and condom use finds foundation in societal views about sex and sexuality as sin. Throughout the Normative task, the study will make use of Louw's Integrative Christian Spiritual approach to Sexual Ethics to reflect theologically and ethically on humanity's view of sex and sexuality. However, in practical theology, it is often found that there is a cross disciplinary dialogue within human sciences. The Normative task will therefore attempt to relate the wisdom of God to the worldly wisdom of human science by referring to other disciplines (particularly Psychology) too.

5.1 INTRODUCTION

The harsh realities of HIV and AIDS call for re-examination of the understanding of human sexuality: the link between sin and sexuality is profound and it publicises sexuality that used to be private. The focus on sexual ethics has been grounded in the understanding of human sexuality: Both concepts have contributed to the stigmatization of the HIV epidemic. Sexual ethics does not consider the concrete realities of human lives: This leads to further stigmatization, judgement and stereotyping of people living with HIV because of the belief that a person living with HIV failed to live according to the sexual ideals of Christianity (Wangen, 2010: 448).

For this reason, one should opt for a theological interpretation of the Integrative Christian Spiritual approach to sexual ethics that might give one a way of expression of the Christian identity and faith without excluding or marginalising people (Wangen, 2012: 448, Louw, 2012: 206).

5.2 THE HUMAN BODY AND SEXUALITY

The human being has an embodied existence; however, the embodied existence of a human being has suffered under an ambivalent interpretation. This ambivalence spills over into the paradigm of human sexuality. As a metaphor for the life of Christ, the body takes on a more positive meaning as the body of Christ forms part of the foundations of Christian theology if one looks at the sacrament of communion as one example. Modern theology emphasised the *incarnation paradigm* as a confirmation of the human body. Let's consider the following quote in support; 'within the incarnation of Christ the whole of the sexual, psychological, biological, and emotional and spiritual being is affirmed' (Patterson, 2009: 45). It is often stated that there is no greater affirmation than this.

The incarnation paradigm has a limitation; according to Louw, the incarnation paradigm represents a legalistic or perfectionist realm by which an individual measures their behaviour. Under the incarnation paradigm, individuals strive to be like Christ (What would Jesus do?). Humanity could never achieve the status of Christ and humans could never fulfil the mediatory function of Christ between humanity and God; therefore, within the incarnation paradigm, people will constantly be (feeling like they are)

in a state of failure (Louw, 2008: 274-275). If this is considered in relation to the people living with HIV and AIDS, the understanding of the human body is one of enslavement in sin; this contributes to the shame of those who experience stigmatization. The body is full of sin, as HIV and AIDS are considered results of sin, and the person is assumed to be 'bad'. The result of this kind of thinking is that sex is a sinful and shameful activity (Wangen, 2010: 440).

In extension to this thought, sex and sexuality are considered by some to be an impediment to the relationship with God; whilst others agree that sexuality is permitted in the institution of marriage. Thus, this analogy deducts that sexuality manifests in either complete faithfulness to one's spouse or complete abstinence (Wangen, 2010: 440). This discourse has resulted in sexuality being surrounded by an aura of shame and guilt.

It should be noted that sex was considered sinful and shameful long before the HIV epidemic. HIV, however, has highlighted the problem. Silence about sex, particularly in the churches has contributed immensely to the problem of stigmatization of HIV as a sexually immoral consequence. Ultimately, HIV has illuminated the silent stance the church has taken with regard to sexuality (Wangen, 2010: 440). This silence should no longer be accepted, as it has resulted in the stigmatization, discrimination, marginalization and stereotyping of people; often leading to not only the denunciation of their human dignity, but also to their death. Taboos hinder people from talking about sex, particularly women; as women are expected to be 'pure'/virgins.

What should the approach to sexuality be? Is one not meant to challenge these 'silent' discourses? Is it not the obligation to deconstruct the existing paradigms of sexuality? What ought to happen in order to 'destigmatize' the notions of sexuality, HIV and HIV positive people? What approach to sexuality could be taken to actualize and promote the human dignity of the other? What is God's will for how one should be thinking and feeling about sex and sexuality? In other words, what ought to be the understanding of sex and sexuality in order to transform the present realities about sex and sexualities into good practice? The present realities about sex and sexuality that form the foundation for the stigmatized beliefs and attitudes people have about HIV and AIDS and condom use (as determined in the Interpretive task – Chapter Four). Louw proposes a new understanding of sexuality. He formulates that sexuality plays a fundamental role in the

establishment of an experience of soulfulness. Sexuality should therefore be grounded in the realm of intimacy.

5.3 A CHRISTIAN SPIRITUAL APPROACH TO SEXUAL ETHICS

Louw formulates that there is no indication of human sexuality in Christian spirituality and that the topic of sexuality is generally excluded from the realm of spirituality. Therefore, a spiritual realm for marriage does not discuss the notions of human sexuality either (2012: 202).

From an integrative Christian spiritual approach, the argument is that both sexuality and corporeality are sacred spaces in all forms of human encounter – even the genitals should be treated as sacramental tools for display of compassionate intimacy. In essence the genitals are corporeal tools of fidelity and intimacy and they are vital for the transfer of intimate love. They are sacramental because they 'enflesh' grace and possible procreation of life. Coitus[7][8] makes sustainable love relationships permanent and intimate love enduring. The introduction of a condom in this understanding seems distorted when viewed in this light; however, sexuality in the realm of responsibility and promotion of the human dignity of the other might enlighten on this distortion. Let's first consider the formulation of an integrative Christian Spiritual approach to sexuality.

In his formulation of this integrative approach, Louw argues that sexuality is part of humanity's being functions: it is a relational issue, embedded in both the spiritual and physical realms of life. Sexual love unites and integrates the physical realm with the spiritual and existential realm of life. In his book, *Network of the Human Soul,* Louw formulates the concept of sexual love as follows:

- Sexual love is self-liberating; expressing one's self-affirmation and desire for growth. Without self-love and maturity, genuine intimacy is impossible; for intimacy depends on one's spiritual maturity and a person's sense of self-worth.
- Sexual love is bodily related; as it is connected to sex and bodily drives – it includes the dimensions of satisfaction of the sexual drive.

[7] Coitus can be understood as the embodiment of soulfulness is a marriage. It is ultimately the mechanism through which "permanence becomes trustworthiness and faithfulness" (Louw, 2012: 88). Under this understanding it becomes impossible to separate true *jada* from human dignity; as coitus is a promise and a covenant: I will never reject you as a person (unconditional love) (Louw, 2012: 88).

[8] Coitus means; sexual intercourse within the realm of intimacy and unconditional love.

- Sexual love includes mutuality and is therefore other-enriching and other-empowering. Sex is then the search for completion in the other person.
- Sexual love should be honest and convey trust.
- Sexual love implies commitment; committing oneself faithfully to a relationship. Marriage – partners for life as a covenant of love, always in a process.
- Authentic sexual love implies responsibility, which includes a social responsibility. It should express values that enhance the larger community and is sensitive to cultural values.
- Sexual love should be geared towards life fulfilment and the healing of life; to prevent estrangement, isolation and rejection (Louw, 2012: 202-203).

Kennedy refers to healthy sexuality as the seeking of erotic pleasure in the context of tenderness and affection (1980: 16).

Pathologic sexuality is motivated by selfish needs for reassurance and relief from non-sexual tensions.

Diagram 5.1: Healthy and Neurotic Sexuality:

Healthy Sexuality	**Neurotic Sexuality**
Give and receive pleasure	Excessive giving and taking
Constructive and sensitive as to gender and partners	Not taking diversity and difference into consideration
Relates erotic tensions to the context of affection	Triggered by non-erotic tensions; more apt to be more compulsive in patterns of occurrence

How is neurotic sexuality then related to promiscuity and pornography?

After considering the above bullets, one can see that the acknowledgement of the *other's human dignity* become a fundamental part of sexuality. Promiscuity and pornography denounces human dignity and identity: Consider the following:

Promiscuity is a crisis of human sexuality as it points towards a free sexual expression without any limitations, boundaries, norms, values, separated from the gender paradigms of male and female, as well as form of love and intimacy. Promiscuity is biological functionalism and it is divorced from the ethics and aesthetics of sexuality and love.

The other is acknowledged for their sexual physicality and not for their enfleshed soul. Moreover, by it is meant sexual immorality and infidelity – the misuse of sex for immoral purposes. Promiscuity is the rejection of the other; changing trust into mistrust; love into lust (Louw, 2008: 364-365). Now the question is; what makes the sex act promiscuous?

- When there is a narcissistic focus on the sexual organs that function merely as instruments of lust: isolated from the human I (denial of human dignity), and a sound value system.
- When sex is an instrument to mechanise the human body; the sex drive is separated from meaning, destiny and value. The penis and vagina become 'things' not sacramental tools; denounce the human I (dignity and identity) of the self and the other.
- When sex and sexuality are isolated from love as an expression of self-respect and respect for the other – sexuality becomes isolated from the realm of intimacy.
- When sexuality becomes an end in itself; without meaning for the person – purely bodily function.
- When sexuality is separated from moral decision making and ethics of responsibility. Sexuality becomes no more than an abuse of power (Louw, 2008: 366).

Similar to promiscuity, one can consider pornography under neurotic sexuality. Pornography refers, very specifically, to the sexual exploitation and the dehumanisation of sex so that human beings are treated as things. It points to the unequal misuse of power and violent sexuality; *animalising* human sexuality and promoting promiscuity. This in effect is violating the dignity and rights of the human being through exploitation and commercialisation of sex. Pornography then reduces sex to an animalistic action and tends to rob sex of intimacy and tenderness (Louw, 2008: 366-367). The central issue is not nakedness, as biblically there is no objection to nakedness. Rather, it has to do with the promiscuous intention of the viewer. The other is viewed only in their sexual physicality; a space of denial of the enfleshed soul, being functions and qualities of the other person. Sexual love should be fundamentally different as it moves towards the ultimate position of intimacy – a position of unconditional love and acceptance. Louw formulates it as follows:

- Sexual love should be joyous; release physical and psychic tensions.
- Love-centred sexuality is inseparable from reconciliation and justice. The focus is on mutual empowerment.
- Sexual love is accompanied by imagination and creativity in the realm of pro-creation. Humans are regarded as co-creators with God – a gift from God.
- Love-centred sexuality should be spiritual and therefore aware of the spiritual quest for meaning and dignity. In Christian spirituality, one can say that sexuality should be sacramental. Sex is a gift of God: a gift of the ultimate intimacy that is somewhat representational of his unconditional love for us.
- Love-centred sexuality 'is the most personal, intimate and sacramental outward expression of the inner physical and spiritual love which God has given. Sexual intercourse in Christian marriage is the highest symbolic act the bodies are capable of to give thanks to the God of love (Louw, 2012: 203).

In the ancient Hebrew, the word intercourse is called jada; the word refers to a unique type of personal communication and reciprocated acknowledgement of one's spouse. Essentially, Intercourse is then meant to establish a commitment in order to enrich the other within a space of unique, unconditional love (an experience of unconditional acceptance, without the fear of being rejected) for the other. Coitus becomes a deepened disclosure of the personal knowledge, spiritual knowledge; it is about ensoulment within the reality of embodiment. Sex, in this understanding, is then an expression of validation, love, commitment and personal affirmation (Louw, 2012: 204). Furthermore, it is an expression of unity or bondage that enfleshes God's grace in such a way that mutual love in the sex act is a constitution and affirmation of the bond of fidelity and trust.

Now the question is; why should one be focused on the importance of the body and its sexual functions in an integrative approach to human and Christian spirituality?

The implication for an eschatological interpretation of Christian anthropology is the following: the body attains a new eschatological status as an expression of the indwelling presence of God's spirit. The new status of a new being in Christ is theologically linked to Christ and the work of the spirit. The identity of salvation becomes substantially more important than the gender differentiation or even sexual differentiation (Louw, 2012: 204). Humanity is all one in Jesus Christ. In other words; the incarnation of

Christ and Christ's spirit in our human bodies, acts as a means of justification for the protection thereof.

To further comprehend the status of the body, one should consider the word 'temple' as a referral to the body in the Old Testament. This word was referring to the most holy part of the temple. Only the highest priest was allowed to enter it once a year; here, the high priest received a message from God. Under this metaphoric, the body becomes the very embodiment and enfleshment of God's presence; if looked at pneumatologically. This is what is meant by *the inhabitational approach to embodiment and human sexuality* (Louw, 2012: 205). Even in sexuality, one must display the fruit of the spirit (Charisma) due to Humanity's new eschatological identity.

Louw formulates that humanity needs to understand the 'what' of human sexuality before they can understand the 'how' (2012: 205). Rephrased, the purpose and the meaning of sexuality needs to be understood in order to actualise the human dignity of the other and establish a realm of ultimate intimacy. In Louw's view, the core issue in human sexuality is the spiritual notion of intimacy; the need to be accepted completely and unconditionally, without the fear of rejection (Louw, 2012: 206-207).

With regards to the HIV epidemic, the notion of condomising in an integrative Christian spiritual perspective becomes more than the use of a condom; it enters into the realm of 'compassionate intimating'. 'Humane' sexuality is about the acknowledgement and actualising human dignity for the other; it is about justice and wholeness. In light of promiscuity, sexuality is about faithfulness and integrity and ultimately, intimacy (Louw, 2012: 207). The notion of 'compassionate intimating' represents the dynamics of embodiment and the declaration that the human body is more than its mere physicality. Louw argues, that for this reason the human body should be read as a embodied space for the nurture of intimacy and a corporeal location for the soul in the intimate sexual encounter (2012; 207).

The notion of faithfulness then links to the understanding of marriage. Paul argues that marriage is an institution one enters into when one is unable of practicing self-control (abstinence); it is, for Paul, better to marry than to be aflame with sexual passion (Wangen, 2010: 441). The issue of marriage in this understanding is that it becomes an issue of responsibility and not of sex. However, the two comprehensions cannot be separated as they are concurrent terms.

In the writings of Augustine, two tendencies emerged in his writing about marriage and sexuality: (a) the ascetic tradition of sexuality (abstinence) that feeds on suspicion and sexual desire and (b) the reinterpreted understanding of Christian marriage as an affirmation of the bond, sex and family. Under the latter, Augustine developed a sacramental understanding of marriage as an institution disclosing profound truths about the Christian faith. The emphasis placed on purity, virginity and wholeness had lasting implications on the view of human sexuality throughout history. Even Martin Luther was particularly concerned with sexual immoralities in his writings, yet he too formulated the essence of his understanding of human sexuality as a gift from God (Wangen, 2010: 442).

It therefore becomes evident that the comprehension of the purpose of sexuality cannot be separated from the understanding of the purpose of marriage. What is the purpose of marriage? Is it merely an institution where sexuality just happens? In light of the above description and the understanding of sexuality and intimacy as a realm for faithfulness and integrity; how does the institution of marriage coincide with the above understanding of sexuality?

5.4 MARRIAGE AND SEXUALITY

In the old Israeli culture, the contract of a marriage was binding once the sheets of initial sexual intimacy were presented to bride's family. This contract was a means transference of responsibility as the groom acknowledged that he would be taking the responsibility for the life and welfare of his bride from her parents upon himself (Louw, 2012: Class Notes). Fundamentally, marriage and sexuality was a state of responsibility and polygamy was not frowned upon: if a man was able to care for and take *responsibility* for more than one wife, he was free to do so. Nonetheless, sexuality and proof of sexual intercourse was the binding contract of marriage, and the affirmation of responsibility. Therefore, sexuality, as well as marriage functioned in the realm of responsibility for the other (Louw, 2012: Class Notes).

Many agree that sexuality is permitted in the institution of marriage. Sex and sexuality is not sinful if it happens in the sacred space of marriage. In contemporary society, marriage is viewed as 'something' and people build their dreams around the idea of a 'perfect marriage'. But what is a perfect marriage exactly? How does a couple achieve a

'perfect marriage' status? Happiness becomes the ideal for a perfect and successful marriage. Happiness, however, is the outcome of a very specific stance in life and is based on the quality of the being-functions in the relationship. Happiness is therefore alternately related to the notions of aptitude, attitude, maturity and one's interpretation of love. Happiness is directly linked to human *intimacy* as discussed above. Happiness corresponds then to a specific mode of being within the *we-space* of a marriage relationship. Happiness is not inevitable and it could be considered as the eventual surprise when one actually discovers the true mechanics of networking within the we-space of intimacy – marriage (Louw, 2012: 87). Furthermore; happiness takes on an individualistic form as it is derived from the individualistic discourse of "I want happiness in a relationship". Individualist thinking, ironically, could most likely lead to 'un'-happiness. A paradigm shift in thinking should therefore take place; from an individualised 'me-culture' to a more interconnected, relational 'we-space' when it comes to understanding marriage – in an attempt to move towards a space of intimacy (Louw, 2012: 87).

In life, as in relationships, one tends to have expectations. For example, when you pick up a pen, you expect it to write. When it does not write, one is often disappointed. Happiness is then what happens when something functions according to its purpose (design) – when the pen writes (Louw, 2012: 87). The question is then: What is the purpose (design) of a marriage? What is the character of a marriage? And what happens if the marriage doesn't lead to 'happiness'? What is a marriage and what is a marriage not? Some people understand a marriage as something that you enter into, like a contract. Some see it as a lifelong partnership. Others even formulate that it as an escape to a better life with someone if your current single life is miserable.

The paramount question that should be asked is what is the design of a marriage or what should the character of marriage be or is it just an experiment which happens by change? People leave each other if it doesn't work out and divorce is humanity's way out.

It seems there is no easy answer to these questions and a different question should be asked; what is the network of marriage interaction and communication between couples within the we-space of spouses? The fundamental question is a hermeneutical one: can one understand the dynamics of a marriage relationship?

These are difficult questions, so let's consider the following hermeneutical question in the hopes of an answer: how can one identify theologically the dynamics of a marriage relationship? What can one say about the we-space of marriage is that couples can't 'join a club'. Unlike the universalised understanding of marriage, the institution thereof is not there to produce only wealth or children (Louw, 2012: 88). Marriage is also not a brothel for personal need satisfaction. In the bible, there is no perfect example of the perfect marriage. The bible is not clear about what 'the perfect' marriage is about. There is no healthy written recipe for marriage in scripture. However, this does not necessarily mean that there are no theological principles for marriage. Louw provides the following guiding principles that can be used for a reflection on the *theology of marriage* (Louw, 2012: 88):

Firstly, the bible is against promiscuity, not merely because it is the holy bible that guides morality, but also because promiscuity is considered the denial of the human dignity of another. Love and marriage are inseparable and it is connected to faithfulness and seen as covenantal. Because of this covenanted nature, it should reflect something on the faithfulness and trustworthiness of God. It should ultimately represent a space for fidelity and grace.

Secondly, sexual intimacy and coitus are essential components of a deep, personal relationship of communion and communication. The word *jada*, as discussed previously, is used to describe sexual intimacy. Jada is the personal knowledge of the uniqueness of the other and the unconditional acceptance of this uniqueness. The goal of sexual intimacy is the enhancement and enrichment of the other's human identity and dignity; an unconditional love for the being functions of the other. This stands in contrast to the mere exploitation of the body of the other, which does not fully respect and accept the human dignity of the other.

Lastly, intimacy is not based on simple romantic love that is often depicted in the movies. The rose petal sprinkled and box of chocolate love that is often ignorantly expected of love and romance. The we-space in the bible is based on a unique understanding of *intimacy*; the choice which represents an acceptance of responsibility for the other – unconditional love and acceptance for the being functions of the other (Louw, 2012: 88). Thus, love is about a "yes, I accept you" now, without a fear of being rejected later or ever.

These guidelines can be paralleled with the purpose of sexuality spoken of earlier. Intimacy in the bible then sets a norm: love one another as Christ loved us as He gave His life in sacrifice. Intimacy in the we-space, in Christ, then indicates a space of grace and reconciliation that should be exemplified and exercised. According to Ephesians 5: 22-23, our position in Christ (the indicative of justification) places marriages under an imperative: sanctification. The norm is therefore to love one another as Christ loved the church and gave his life as a sacrifice (Ephesians 5: 2). In marriage, the presentation thereof should be so that it bears witness to the faithfulness of God. Bride and groom's relationship is often presented as the relationship between God and the church (Louw, 2012: 89).

Theologically speaking, the function of the we-space in a marriage is to create a space of intimacy[9], which represents the *unconditional love*[10] [11] of God's grace. Louw then argues that marriage is about the covenantal relationship; the promise of faith and mutual trust. This promise can be connected to the promise of God to be faithful to us, as He promised to be our God no matter what.

When intimacy is understood like this, the network of the couple's communication starts to experience 'soulfulness'. The notion of the soul here then has to do with (a) the quality of the we-space (the relationship space) as a demonstration of grace and the unconditional love referred to earlier, (b) the quality of love as the sacrificial love of Christ, (c) the quality of togetherness in an expression of the fruits of the spirit or Charisma (Louw, 2012: 89). Soulfulness and the soul cannot be separated from the body, as the body is an 'enfleshment' or embodiment of the soul and the body is 'ensouled' by the soul (Louw, 2012: 207-208).

Pathology in intimacy lies in two things. Firstly, within the expectations of marriage there is the threat of disappointment. Secondly, there is the possibility of the feeling of rejection entering into the conative and cognitive realm of the we space: For example, he or she does not want me so why should I be committed to him or her? Pathology of

[9] Intimacy is seen in the marriage relationship as a metaphor for the faithfulness of God (Louw, 2012: 86).
[10] Marriage is considered to be sacramental when the we-space represents unconditional love (Louw, 2012: 86).
[11] Unconditional love in marriage is the promise that one will accept the other's entire human being, with all their qualities and being functions, without the limiting fear of rejection or isolation (Louw, 2012: 86).

intimacy is linked to a third factor (God, work, religion, sport etc): this third factor functions as a replacement, in the we-space, of the other (Louw, 2012: 90). A hermeneutical understanding of the we-space should not be presented as the fool proof plan for a marriage; nonetheless, it gives one a good understanding of the networking of the we-space and helps one understand the 'ethics of love' and the 'ethos of intimacy'.

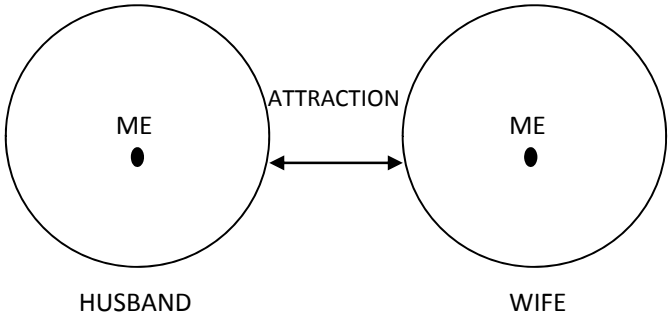
Health within a marriage relationship is about love connected to understanding. It's about the quality of being-functions as determined by norms and values; power not exercised as self-maintenance, but as service and sacrifice (Louw, 2012: 90). The fundamental question in light of the understanding of the ethics of love and the understanding of the networking of the we-space is then: are these two people committed enough and mature enough to let this we-space enrich their experience of intimacy and their mutual commitment to love? Without commitment the we-space would be an obligation and not a vocation (driving force or calling) (Louw, 2012: 91). The we-space should be viewed as having no beginning and end and should be understood as a circular process. The challenge is then to understand the mechanics and dynamics of this circular process.

Growth in a marriage is about the challenge to expand and enrich the functions of the we-space. This expansion refers to the enhancement of the quality of togetherness and interconnectedness through a qualitative understanding and acceptance of the being-functions and unique qualities of the other. The we-space grows when the quality of the being-functions are enriched. When being functions reflect maturity and human dignity, the we-space has space to develop and grow. A marriage can be enriched when 'our interests' get preference over 'my interests' (Louw, 2012: 90). Louw provides the following depictions in order to comprehend the we-space:

a. *The Embryonic stage**:*** where one's own individuality is predominant and communication is determined by your unique personality and needs. The human 'I' is very predominant and the person is very 'me-focused'. The body is important here as the likes and dislikes start with the physicality of the human body; namely attraction (Louw, 1996: 14). The other becomes assessed in terms of beauty, embodiment, eroticism etc. Under this stage, the notion of an artificial image is present; the maturity is gained through the other and not though spiritual wisdom. (Need to know spiritual identity to gain maturity). A problem in

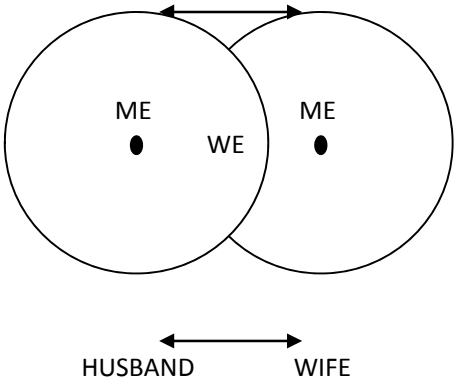
marriage is often selfishness and a self-preoccupation – not considering the human identity of the other. From this stage a 'we'-personality and conscientiousness should develop.

Figure 5.1: The Embryonic Stage:



b. *The Discovery stage:* is a stage where you get to know one another. In this stage, the couple learns to appreciate the other's positive qualities; ultimately discovering the uniqueness of their partner. This stage is a stage of mutuality, a stage of fellowship and sharing (Louw, 1996: 14-15). The focus moves away from the self and towards the unconditional love for the uniqueness of the other – agape. However, more appreciation of the capabilities and qualities of the person need to be explored.

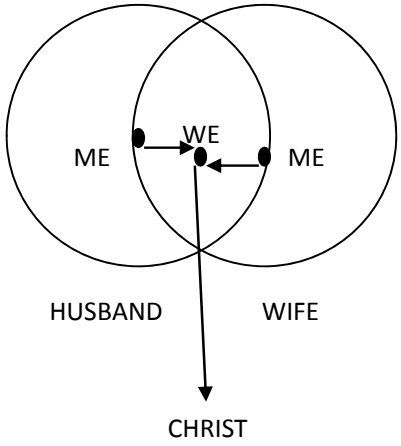
Figure 5.2: The Discovery Stage:



c. In *the complementary stage***:** the we-space becomes a space where the couple *invests* in one another, without receiving any acknowledgement back. A space where true intimacy and maturity can be reached; where unconditional love – acceptance without the fear of rejection – can be experienced. In this stage,

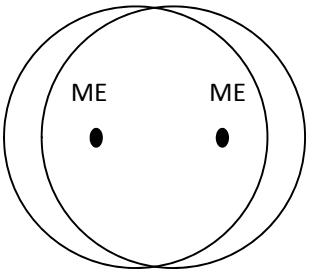
partners *enrich each other with agape*; a space where the true human identity and dignity of the other is acknowledged and loved, without the fear of rejection. A space of reconciliation and grace presented through the 'fruits of the spirit' (Charisma) because of the new pneumatological identity in Christ (Louw, 1996: 15). A covenantal understanding of the we-space implies the following question: *not* "What can you offer me in order to make me happy?", *but* "What can I share with you in order to respect and protect your identity and dignity?" Through the empowerment and unconditional acceptance of the other, the we-space is strengthened and expanded.

Figure 5.3: The Complete Stage:



d. When the level of intimacy is too intense and too much, the two individuals become *enmeshed* in their identities. This is an undesirable outcome. The identity of the other becomes lost in the we-space (Louw, 2012: Class Notes). On this level of intimacy, the identity and dignity of the other cannot be unconditionally accepted or loved as the identity is lost in the we-space.

Figure 5.4: Enmeshed identities:



For growth to take place on the we-space the question should be posed to the self; how can I enrich the other and invest in the other, without having the expectation to be paid back? In the actualisation of this question, the we-space becomes fundamentally more important than the me-space. The 'I' mentality disappears. Trust and faithfulness become the cornerstones of the we-space relationship and ultimately intimacy develops as the mutual love. Similarly, the understanding of the purpose of sexuality and the comprehension of the design of marriage both conclude in the realm of intimacy and the movement towards ultimate intimacy. Marriage becomes sacramental when the we-space represents unconditional love, i.e. the promise that one will accept the other unconditionally for who the other is as a human being, despite limitations and without the fear of being rejected and isolated. In this understanding, intimacy then becomes a metaphor for the faithfulness of God and a promise for continuity and permanency.

5.5 CONCLUSION:

Throughout the Descriptive-Empirical and Interpretive tasks, it was determined that condoms are being stigmatized because of attitudes and beliefs people hold. These beliefs and attitudes were found to be grounded in cultural, religious and spiritual discourses about HIV and AIDS and condom use. Moreover, the Interpretive task investigated the dynamics of stigma and stigmatization and proved that the stigma was fuelled by the beliefs and discourses numerous cultures and religions hold about sex, sexuality and sexual ethics; as sin was being related to sex and vice versa.

With the Normative task – under this chapter - the research followed with an ethical reflection on the Interpretive task, where the research embarked on answering the question; what ought to be the perception and understanding of condom use? Through theological interpretation, Louw's theory of an Integrated Christian Spiritual Approach to Sexual Ethics was consulted. The Normative task consulted theories from other disciplines (Psychology) to assist in the development of ethical principles and to channel and transform the present views of sex and sexuality towards moral ends and good practice (Osmer, 2008: 135-137).

Through theoretical interpretation and ethical reflection, the Normative task answers the question of what ought to be going on? The chapter looked at sexual love, which Louw describes as something that unites and integrates the physical realm with the spir-

itual and existential realm of life. The notion of healthy sexuality is formulated by both Kennedy and Louw: Kennedy describes that healthy sexuality is the seeking of erotic pleasure in the context of tenderness and affection (1980:16). Louw refers to healthy sexuality as the unconditional love and acceptance of the other without any fear of rejection (2012: 204-205). For Louw, the true purpose and meaning of sexuality needs to be fully comprehended in order to actualise the human dignity of the other in order to establish a realm of ultimate intimacy; the intimacy God has intended for humanity (2012: 205). Wangen explains that Martin Luther described human sexuality as a gift from God. Herewith, the Normative task discerns God's will for sex and sexuality.

One cannot separate the purpose of sexuality from the purpose of marriage. In the Normative task, the question was asked; how does the institution of marriage coincide with this new comprehension of sexuality? It was deduced that the function of the we-space in a marriage is to create a space of intimacy which represents the unconditional love of God's grace (Louw, 2012: 207). Louw theorised that growth in the we-space is about the challenge to expand and enrich the functions of the we-space; the enhancing of the quality of togetherness. The Normative task discussed the different stages in which Louw explains this growth can take place. The theory also assists in seeing how sexuality can be transformed and be viewed as it was intended, as opposed to being viewed as sin and therefore a tool to reinforce stigma. Louw's theory can be seen as a reformulation of the understanding of the purpose of sexuality from a hermeneutical understanding. In this view, health in marriage is about love connected to understanding; the comprehension and unconditional love and acceptance for the other person's being-functions. Ultimately, this chapter assists one in comprehending that human sexuality is a part of the human identity and therefore forms part of human dignity. Louw describes that as human beings there is one ultimate need, which is the need to be unconditionally loved and accepted without the fear of being rejected (Louw, 2012: 87-88). Concluding the answer to the question of what the understanding of sex and sexuality ought to be. In all, stigma surrounding sexuality and HIV and AIDS leads to the rejection of the other and so the fear of rejection; which is a denunciation of one's human dignity.

The relevance of the exploration of a new approach to sex and sexuality shows how human belief systems transcend through human expectations and meanings ascribed to

things. Understanding this new way of looking at sexuality from an understanding of true purposeful and meaningful intimacy helps one understand that the ideas about sexuality are constructed according to beliefs and expectations about sexuality, sex and even marriage. Should these beliefs and expectations not be actualised one is disappointed in the result. Considering this, it brings the research yet again to stigmatized ideas about what is 'healthy' sexuality or what is a 'healthy' marriage. Should one choose to look at things a little differently, one might be able to break down the expectations and beliefs about sex, sexuality and even marriage; as the true purpose of sexuality, sex and marriage is fully understood and results in the affirmation of the other – the affirmation of the human dignity of the other and ultimately the de-stigmatization of thinking. This affirmation finds confirmation in unconditional love for the other, the unconditional acceptance and love of the other, with the absence of fear of rejection (Louw, 2012: 207). However, the exploration of a new paradigm for sexuality is not enough to move towards de-stigmatization. Looking at sexuality is not enough to destigmatize the HIV and AIDS phenomenon in itself. One then has to ask; how does one move towards de-stigmatization? What is the role of a pastoral counsellor to enable a movement towards de-stigmatization? What should the pastoral approach be to the HIV and AIDS epidemic and how should one respond to the stigma that fuels the epidemic's fire?

There is one last question which leads to the final part of the Hermeneutical literature review and the final task, namely the Pragmatic task. The main research question under this task is; how might we respond? How might we respond to the stigmatized perceptions and understandings surrounding condom use, sex and sexuality and HIV and AIDS? Considering the findings of the research thus far, one needs to question what the best response will be to the stigmatization identified. How should one respond in order to achieve the healthy understanding of sexuality just discussed under the Normative task?

Louw proposes a paradigm shift that needs to take place in order to de-stigmatize HIV and AIDS, condom use and sexuality. Kiriswa proposes a *pastoral approach* that emphasises the importance of HIV education programmes and preventative education. Let's consider both of these in the next chapter; the Pragmatic task (n.d.: 83).

CHAPTER SIX:

THE PRAGMATIC TASK: DE-STIGMATIZATION: A CHALLENGE TO PASTORAL CAREGIVING

6.1 INTRODUCTION

Throughout the Normative task, the study looked at the purpose of sexuality and determined that sexuality cannot be separated for the understandings of the purpose of marriage. Exploration of the notions of healthy sexuality and neurotic sexuality determined that our view of sexuality influences our stigmatized ideas about HIV and AIDS and condom use. Louw describes that human beings has only one ultimate need, which is the need to be unconditionally loved and accepted without the fear of being rejected (Louw, 2012: 87-88). In all, stigma surrounding sexuality and HIV and AIDS leads to the rejection of and so the fear of rejection; which is in all a denunciation of one's human dignity. That said, what should our response be? How does one move towards de-stigmatization from here? How does one combat the stigma that disables knowledge as an empowerment tool? In other words; how does one deal with this stigma? How might we respond to the stigmatization of condom use to move towards de-stigmatization? This chapter commences the Pragmatic task, an effort to answer this question in the final part of the Hermeneutical Literature Review.

After the ethical reflection in the Normative task, the study will now move towards a practical theoretical interpretation of the findings and suggest possible practical conclusions and approaches that might guide one through the process of change and movement towards de-stigmatization. In other words, the Pragmatic task will present practical suggestions on how we might respond to stigma and perceptions about sex, sexuality, HIV and AIDS and condom use. The Pragmatic task will be initiated by looking at HIV Education and Awareness Programmes.

6.2 HIV EDUCATION AND AWARENESS PROGRAMMES

Preventative education has been the most effective means of combating and controlling HIV and AIDS (Kiriswa, n.d.: 83). The church needs to promote awareness and

prevention in an attempt to break the culture of silence surrounding HIV and AIDS; to overcome ignorance and resistance. Bishops in Kenya declared the following:

> We commit ourselves to the expanding and strengthening our pastoral care programmes for youth in and out of school to bring the lifesaving message of chastity to them… we recommend that this be done in collaboration with parents and other members of the community. This will ensure that HIV and AIDS Education is given within the context of traditions, beliefs, and faith values, behavioural and educational norms of a particular community. Purely secular approach to giving information without a sound moral back up would provide the youth with the strength they need to achieve and uphold a behavioural change (Catholic Bishops of Kenya, 2000: 13).

Kiriswa explains that HIV Education programmes should be geared at the *meaning* of HIV and AIDS; thus, exploring all of the dynamics associated with it (Kiriswa, n.d.: 84). The focus of the education should not only be geared towards the risky and behavioural, but also on the circumstance that promotes and prevents the spread of the virus. Most importantly, education should encourage people to engage in the fight against stigmatization and the virus. Yet, the education should also be communicated in accordance with authentic values of life, love and sex. Education of fidelity and sexual abstinence should include customs, myths, practices and beliefs that contribute to the spread of HIV and AIDS. Cultural practice and social contexts such as promiscuity, wife inheritance and polygamy should also be discussed during this education, so that all the dynamics can be thoroughly be explored in relation to HIV and AIDS. But, ultimately, the true purpose of sex, sexuality and marriage should also be explored (Kiriswa, n.d.: 84).

HIV and AIDS education programmes should be designed to assist the community to acquire realistic knowledge and attitudes instead of believing that AIDS is a curse, a punishment from God, a result of only witchcraft or a disease restricted to a particular group of people (Kiriswa, n.d.: 84). Furthermore, the HIV education programme should assist people to overcome stigma of AIDS and realise that people living with HIV and AIDS should not be alienated from love and unconditional acceptance; like other people, HIV positive people should be treated with respect and dignity. For this

reason, all educational programmes should be geared towards minimizing denial and stigma against AIDS at all levels (Kiriswa, n.d.: 85).

Kiriswa explains that educational interventions and psychological counselling is not enough when one is addressing the HIV and AIDS epidemic (n.d.: 85). People living with HIV and AIDS are at risk for being viewed as irrelevant to society. Arguably, these people need sacraments and prayers. Establishing a spiritual caring relationship can become a vehicle for spiritual assistance for HIV positive individuals. Kiriswa argues that; '…people should be visited and encouraged by their pastor to receive the Sacrament of the Anointing of the Sick and Holy Communion for their spiritual healing and strength to endure the pain and suffering…' (n.d.: 85). Pastoral care and counselling is also needed for the Christian faith and values that form part of the process of helping people living with the virus; as it assists people and families in coping with the devastating consequences of the virus (Kiriswa, n.d.: 85). The question then arises; what is pastoral counselling for people living with HIV and AIDS? How should these pastoral methods be implemented in an attempt to break down the all-encompassing stigma that surrounds the HIV phenomenon?

A possible suggestion of a pastoral approach of educational interventional nature is the SAVE prevention methodology.

6.3 THE SAVE PREVENTION METHODOLOGY

According to the SAVE prevention methodology, most materials on HIV prevention ignore or under play the impact of stigma, shame, denial, discrimination, inaction and mis-action (SSDDIM). As determined by the research study and the SAVE prevention methodology, there is an assumption that giving people appropriate scientific knowledge about HIV and AIDS prevention will resolve the issues of SSDDIM. The SAVE prevention methodology aims to equip both religious leaders and other HIV practitioners with the tools and strategies necessary to drive the transformation towards de-stigmatization (eds. Chalcraft *et al*, 2011: 2-3). Thus, the SAVE prevention methodology also aims to provide individuals and communities with a resource to help them face their fears and hopefully put an end to the stigma associated with this HI-Virus (eds. Chalcraft *et al*, 2011: 3). Structured to be offered as a course for communities, groups and individual counselling, the model can be understood as follows:

S – Safer Practices

A – Access to treatment

V – Voluntary Counselling and Testing

E – Empowerment (eds. Chalcraft *et al*, 2011: 9)

a. *Safer Practices:* The module of Safer Practice explains that individual sexuality is influenced by friends, family, the media and more. The SAVE methodology argues that within the faith community, the interpretation of scripture and cultural practice has an influence on how people feel about sex and sexuality. Supporting the findings in this research study, the SAVE prevention methodology explains that the feelings resulting from these interpretations influence people's behaviour (eds. Chalcraft *et al*, 2011: 3). The module of Safer Practice allows for deeper interaction between the facilitator and participants, ensuring that participants are able to understand the sexual risk that they might be engaging in (eds. Chalcraft *et al*, 2011: 5). The module is focused on rethinking and perhaps changing attitudes towards sex that are culturally and doctrinally exclusive. The module also looks at how people interact with one another and how relationships work in their personal experience. The change of individual behaviours is not a simple task and therefore the model suggests providing a safe space for people to feel comfortable to discuss issues (eds. Chalcraft *et al*, 2011: 3-5).

b. *Access to treatment* : This module looks at exploring all possible angles of access to treatment with regards to Anti-Retroviral Therapy (ARV's) and more. Not only exploring what treatment entails, but also looking at how ARV's are benefitting the participants, regardless of HIV status, exploring the impact of treatment of HIV, and the HI-virus on the individual and the community (eds. Chalcraft *et al*, 2011: 16). Still, the module explores these issues in relation to SSDDIM and its relation to the Access of treatment, in the hope of moving towards a de-stigmatized mind set of ARV's and people living with HIV that require ARV treatment.

c. *Voluntary Counselling and Testing (VCT):* There are a number of fears surrounding counselling and testing programmes. Counselling in VCT should not be taken

lightly, as it often forms the foundation of those living positively with HIV. The first identifiable fear regarding VCT is confidentiality, as there are some entities that often force people to go for HIV tests, these include, job applications, insurance etc. (eds. Chalcraft *et al*, 2011: 4). The second obstacle is the fear of discrimination when having an HIV test, as many people choose not to have a test because of the fear of discrimination. This stretches even further, as people fear stigma, shame, discrimination, judgement and rejection by partners, families and communities. Under this module, SSDDIM is again applicable and discussed in relation to the module of VCT (eds. Chalcraft *et al*, 2011: 4). For all of these reasons high quality counselling is imperative. The challenge is to provide counselling that can support everyone, identifying ways of ensuring confidentiality and identification of the community leaders who would be willing to encourage and take part in a VCT initiative.

d. *Empowerment:* This module refers to the empowerment through education and advocacy. SSDDIMM associated with HIV remains a major problem in peoples uptake of services associated with HIV and also for people living with HIV and AIDS – as it limits their attainability of productive and healthy lives. Therefore, empowerment of the self and the other remains a vital component in all HIV and AIDS related work (eds. Chalcraft *et al*, 2011: 9). Empowerment involves the access to accurate and contextually relevant information about HIV and AIDS, in order to make informed decisions to protect oneself, one's partner and family from HIV and AIDS. Empowerment in this respect also challenges SSDDIM, moving towards a mind-set of de-stigmatization (eds. Chalcraft *et al*, 2011: 9).

In conclusion, the SAVE prevention methodology is a holistic model looking at all of the aspects relevant to the community to provide and facilitate a contextually applicable and relevant intervention methodology for each group/individual or community (eds. Chalcraft *et al*, 2011: 10). Moreover, the prevention model provides a framework to challenge the stigma, shame, discrimination, denial, inaction and misaction (SSDDIM) resulting from ignorance and fear about HIV and AIDS, and the model looks at ways to move forward, towards a mind-set of de-stigmatized thinking (eds. Chalcraft *et al*, 2011: 10). Thus, the SAVE prevention methodology can be imple-

mented in conjunction with some of the pastoral care and counselling approaches discussed below.

6.4 PASTORAL CARE AND COUNSELLING FOR PEOPLE LIVING WITH HIV

The definition of a pastoral counsellor is often not certain. A clear definition of a pastoral counsellor's role is necessary in order to determine a pastoral counsellor's approach to the issues at hand. It makes sense to consider the role of the psychological counsellor in order to gain some clarity on the difference between the two specialities. Kiriswa formulates that psychological counselling has been defined as the process of assisting others to listen and understand themselves more fully in order to clarify, explore and discover alternate ways in of coping. Similarly, pastoral counselling does the same; however, goals are set in the light of the Christian faith and values. Pastoral care and counselling assist people to grow in their faith and find solutions for their problems (Kiriswa, n.d.: 88). Moreover, the ultimate goal of the pastoral counsellor is to develop the inner potential to bring about fuller growth, personal maturity and spiritual maturity; healing the soul in order to heal life (Cura Annimarum as Cura Vitae). Ultimately, Browning states that the objective of the Pastoral Counsellor is individual reconciliation, restoration of emotional health and psychological growth and openness to God's grace (2009: 12).

6.4.1 Goals of Pastoral Counselling for People Living with HIV and AIDS

HIV and AIDS pastoral counselling can be described as an interpersonal relationship that assists people living with HIV and AIDS to experience the presence of God's grace in their suffering and a space for spiritual healing. It should be noted that spiritual healing does include certain dimensions of psychological, emotional and physical aspects; however, in this understanding, spiritual healing refers to peace of mind and spiritual strength to face suffering and pain though the grace of God (Kiriswa, n.d.: 88).

Kiriswa formulates the aims of pastoral counselling for people living with HIV and AIDS is as follows:

- Instilling courage, self-understanding, self-acceptance and self-love in the realm of faith. This stands in contrast to self-rejection and condemnation.

- Counselling enlightens the notion of the power of hope and it re-establishes a purpose for life; this stands in opposition to despair and hopelessness.

- Pastoral Counselling for people living with HIV and AIDS further utilizes the personal experience of suffering to share in the redemptive work of Christ who too suffered and died and was resurrected for us.

- It also helps HIV and AIDS sufferers to experience solace, support, healing and reconciliation in times of pain and terminal illness; providing them with the necessary coping skills needed to adjust to their changing circumstances and conditions.

- Counselling enhances prayer and communion with God, to move towards inner peace. It also has the ability to reduce stigma through reduction of guilt and anxiety because of the disease.

- Pastoral counselling utilizes an integrative approach towards death and dying, to assist the client in integrating death, dying and suffering into the reality of the daily life of people living with HIV and AIDS. The acceptance of death is considered a natural part of life and if understood in the context of the religious faith, the stress and anxiety associated with it slowly diminishes. The person becomes empowered to approach life with greater openness to a greater being – God (Kiriswa, n.d.: 89).

In Louw's counselling model for people living with HIV and AIDS, he formulates that counselling is about constructive talk, help, change, hope and growth (Louw, 2008: 446). Louw formulates that counselling for HIV and AIDS clients, from a pastoral perspective means the following:

- The establishment of a helping relationship.

- Ensuring a caring system and a space for empathy.

- Defining and articulating the problem (naming it), in order to formulate the story surrounding the problem.

- Engaging in a constructive and structured conversation such as a group discussion, dialogue or verbalization of the problem.

- Teaching and providing coping skills that instil meaningful ways of looking at the problem.

- Finding a way to connect problems with an 'alternate story' or alternate, preferred story.

- Exploring sources for appropriate coping skills and management strategies.

- Empowerment of clients to make responsible decisions, through goal setting and mobilization to action, such as the conscious responsible decision and action of using condoms or being faithful to one's spouse.

- The assessment of God-Images to establish a mature spiritual stance in life; in order to promote hope and growth (2008: 446-447).

There are certain therapeutic theories and tools that can be utilized by the pastoral counsellor. These therapeutic tools might assist the pastoral counsellor to reach the goals and aims of pastoral counselling. One of these therapeutic tools is the use of a client-centred approach in counselling people living with HIV and AIDS.

6.4.2 Client-Centred Counselling Approach to Persons Living with HIV and AIDS

Sickness does not reduce the image of God in People who are living with an HIV positive status; regardless of what the product of stigma has led one to believe. The client-centred approach hypothesizes that all individuals have, within themselves, vast resources to understand themselves and the means to alter their self-concepts, attitudes as well as behaviours (Kiriswa, n.d.: 90). Unconditional positive regard for the client/person living with HIV and AIDS, the client is able to regain a sense of self-esteem and self-worth and an ultimately a positive self-image. Should this be presented in accordance with true unconditional Christian love and support (Charisma), the

clients living with HIV and AIDS are able to accept themselves and their human dignity – given to them by God – regardless of their physical HIV positive status or health conditions (Kiriswa, n.d.: 90).

Another counselling method that can be utilized in pastoral counselling for people living with HIV and AIDS is a Cognitive approach to counselling.

6.4.3 Cognitive Approach to People Living with HIV and AIDS

It is safe to say that our beliefs determine much of our behaviour and the way events are interpreted. The meaning ascribed to these events could lead to stress. It is proposed, according to cognitive counselling approaches, that emotional and behavioural disturbances are learned from one's culture and environment. This coincides with internal stigma; external cultural beliefs are internalised by the individual (Kiriswa, n.d.: 90). The famous psychologist, Albert Ellis, believed that individuals have the power to control their destinies; if one dares to dispute another's irrational beliefs. This involves the translation of negative self-talk into positive self-talk. People living with HIV and AIDS are likely to possess a lot of negative and faulty self-talk due to stigma and discrimination. One might have internal beliefs about being sinners, and being punished by God. As a result, these people carry a lot of guilt feelings. Challenging these irrational beliefs in pastoral counselling might alleviate the guilt feelings. Moreover, it can help these individuals avoid self-destructive thinking that causes their distress (Kiriswa, n.d.: 90).

6.4.4 Reformulation of Personal Meaning of Life

Regardless of the techniques utilized by a pastoral counsellor, the role of the pastoral counsellor is ultimately to assist the client by reformulating their personal meaning of life; finding a new meaning and purpose. Kiriswa poses that a blending of the different pastoral approaches will allow the pastoral counsellor to do the following:

- Assisting the client to maintain a positive view and advance to life through the acceptance of their HIV positive status as a part of their reality. The client will be encouraged to seek treatment and live positively.

- The pastoral counsellor will provide support and unconditional acceptance that will maintain and help to motivate the HIV positive individual's will to live. Harvesting this attitude in the counselling session might assist the client to establish quality rich relationships with others.

- The pastoral counsellor will assist the client in their experience of grief and mourning, before they shift towards a position of integration of the illness.

- Avoidance of labelling the client as a victim is another role of the pastoral counsellor.

- Lastly, the pastoral counsellor can also have a contact session with the family, friends and health care professionals and encourage the establishment of a deeper relationship by showing great tenderness, warmth and solidarity towards people living with HIV and AIDS (n.d.: 91).

Louw proposes an alternate five stage model that will assist the pastoral counsellor in achievement of the above goals in the counselling of people living with HIV and AIDS.

6.4.5 Louw's Five Stage Model for Counselling People Living with HIV and AIDS

6.4.5.1 The Impact Stage

The impact of an HIV positive diagnosis is often accompanied with shock, denial, anxiety and feelings of helplessness. Louw advises that the pastoral counsellor should focus on the basic needs of the client; needs such as the need for acceptance, the need for understanding, love and sustenance (2008: 447).

6.4.5.2 The Regression Stage

Often, as a means of dealing with the shock and grief of the diagnosis and situation, people tend to move into a state of isolation and mourning. According to Louw, internalised anger and a hostile approach to the social and cultural environment are often prevalent in this stage (2008: 447). The feelings of guilt and anger experienced by the client should be acknowledged and dealt with by the client. In order to assist the client

through this stage, the pastoral counsellor should be a beacon of trust by communicating a quality of understanding and acceptance. Love and compassion, as fruits of the spirit, becomes crucial here.

6.4.5.3 The Internalization Stage

This stage is characterized by the process of coming to terms with the long-term consequences of an HIV positive status and the associated pressures; such as the burdens of treatment and disclosure. This stage entails a period of acknowledgement and acceptance of one's alternate story and new reality. Through this process of acceptance, disclosure of one's status becomes a formidable notion in the formulation of one's story (Louw, 2008: 448). The pastoral counsellor is to assist the client in facilitating a space where the client can feel safe enough to disclose. Louw states that; "On a deeper spiritual level an awareness of continuity, endurance and perseverance as an expression of trust and the faithfulness of God must be established" (2008: 448). Hope is then related to the faithfulness of God: this assists in the fostering of and attitude of growth.

Louw argues that a narrative approach under this stage is the most helpful approach, as it takes on a non-blaming and non-judgemental stance to pastoral therapy (2008: 448). Narrative theory centres on the formulation of an alternate story through the enrichment and 'thickening' of an alternate story, separate from the outcome (Louw, 2008: 448).

One of the key tools in narrative therapy is the naming of the problem. This is done by externalising the problem verbally and placing it as separate from the person. This is called externalizing: the person is not seen as the problem, but rather the problem is the problem, and the person's relationship with the problem is the problem (Louw, 2008: 448). For example, the disease is not the person: rather the disease is merely in the body of the person – the HIV positive individual is not a diseased person. This can be understood as the "*de-internalisation*" of external stigma that was initially internalised by the person living with HIV. Ultimately, narrative therapy assists the person in the process of deconstruction and unpacking of stigmatized ideas. The separation allows for new possibilities to be formulated into a preferred story. The preferred story

can serve as a 'counterplot' or anti-problem that illuminates the personal skills, competencies, abilities and beliefs systems of people (Louw, 2008: 448).

6.4.5.4 The Reconstruction Stage

This stage is, according to Louw, directly linked to the process of decision-making and planning (2008: 449). God's promises and faithfulness and confidence in these promises facilitate the process of self-actualization through faith and confidence. This assists the person in the discovery of a new found courage to make the necessary decisions (Louw, 2008: 449).

6.4.5.5 The Constructive Stage

This stage involves the development of a quality of life, which utilises a positive status as a means for growth, quality decision making and goal setting. Louw formulates that; "Within a Christian, spiritual understanding of HIV, the character of God-images will be decisive in terms of developing a positive stance and constructive identity" (2008: 449).

It should be noted that Louw does not intend for these stages to be understood or implemented as a linear structure; rather as a circular process within a spiral model, where the stages are interconnected (2008: 449).

Louw adds that at some point during these stages the notion of disclosure will arise (2008: 449). He further formulates that disclosure and acceptance are intricately linked issues that cannot be separated. Acceptance without disclosure will lead to an artificial life of lies, guilt and anger. Disclosure in the absence of acceptance will inevitably lead to cruelty and inhumane behaviour or treatment, rejection and destructive prejudices (Louw, 2008: 449). Ultimately, disclosure cannot be dealt with without debunking and unpacking stereotypes, prejudices and stigmatized attitudes. The healing of attitudes will arguably result in the healing of the HIV positive person. Disclosure, in effect, becomes a 'burden of responsibility' for the caring environment and society; as the family and the church should be prepared for the challenges associated with acceptance and unconditional love (Louw, 2008: 449).

6.5 THE JESUS-IMAGE AS MODEL FOR COUNSELLING TOWARDS A PASTORAL-SPIRITUAL APPROACH IN PROCESSES OF DE-STIGMATIZATION:

Another possible pastoral approach suggested as a practical response is the Jesus-image as model for counselling. Jesus is viewed as the ultimate model for pastoral care; He responded to the needs of His people the deepest and most honourable compassion, love, mercy, forgiveness, patience and unconditional love. Sofield and Kuhn states: "His whole life was characterised by compassionate responses to those who experienced pain of mind, body and soul." (1995: 35). Jesus allowed for the pain of others to affect Him, to such a point that felt the pain with them, as the suffering divine being. The Jesus-image could also have been discussed under the Normative task, as the Jesus-image model can also provide an argument towards a moral end and ethical discernment of what ought to be going on. For this research argument however, the model provides a pastoral, practical approach suggesting how we might respond to the stigma relative to condom use and HIV and AIDS.

6.5.1 Jesus was Non-Judgemental

"God is not punishing persons living with HIV/AIDS for sins committed" (Kiriswa, n.d.: 92). The notion that God is punishing humanity for sexual immorality is an unacceptable attitude. Jesus accepted people regardless of their sin and physical health status (lepers etc.): this serves as a model for accepting people living with HIV and AIDS. The challenge of unconditional love, acceptance and recognition lies before us if one considers such an inclusive approach to HIV. It is a challenge of radical transformation and change. Pastoral counsellors should encourage people living with the HIV and AIDS to have the courage to encounter and live with HIV negative people in the absence of fear for marginalization, prejudice and suspicion (Kiriswa, n.d.: 92).

6.5.2 Jesus Reaching Out

In the Gospel, one finds ample examples of Jesus reaching out to sufferers in need of help. Pastoral counsellors should, as Jesus did, reach out to those who might be hesitant in seeking assistance, due to fear of stigma and discrimination.

6.5.3 Jesus as Great Listener

Jesus showed patient attendance to the stories of people's lives, their pain, as well as their joys in life, as in the Gospel of Luke 10: 38ff. The pastoral counsellor's ability to enter into the perceptual framework of the world and story of the other and experience their world with true empathy and sympathy is achievable through this Christ-like way of listening. True listening and responding to the personal stories, thoughts and feelings of people living with HIV and AIDS should be genuine, open, respectful and honest (Kiriswa, n.d.: 93).

6.5.4 Jesus' Authenticity

A pastoral counsellor must be real, honest, respectful, authentic and open in all his/her dealings with others; as Jesus was authentic, honest and open with and not reluctant to share his feelings, fears and concerns with His apostles and openly asked for their assistance. This can be witnessed in Mark 14: 34 as Jesus stated the following to His apostles: "the sorrow in my heart is so great that it almost crushes me" (Kiriswa, n.d.: 92). Pastoral counsellors should opt for a congruent stance in counselling to manifest their authenticity.

6.5.5 Jesus as Caring and Selfless

Jesus, as the good shepherd, was dedicated and committed to the caring of His people (flock). His willingness to care and sacrifice for us, His flock is the act of ultimate self-giving and surrenders. Caring for people living with HIV and AIDS requires perseverance, sacrifice and fortitude in order to endure the suffering and heartbreaking experiences associated with HIV and AIDS suffering (Kiriswa, n.d.: 92). The caregiver (pastoral counsellor is this case) often experiences compassion fatigue as one is affected physically, emotionally and spiritually when dealing with death, dying, grief and loss; as commonly found in the realm of HIV and AIDS counselling.

6.6 DANGER OF USING JESUS AS MODEL FOR PASTORAL COUNSELLING

As briefly discussed previously, using Jesus as a guide for ethical behaviour results in Christ's life and work becoming Normative for human behaviour. The 'what would

Jesus do?' motto means that perfectionism becomes the primary ethical principle one lives by, because Christ was without sin (Louw, 2008: 276). The two resulting consequences are: (1) legalism; the constant strive to achieve, try harder and prove yourself, (2) constant pessimism; the constant experience of failure because one cannot compare with Christ and one cannot meet the Christological norm (Louw, 2008: 276).

As briefly discussed in Chapter Five, Louw suggests an inhabitation paradigm as opposed to an Christological paradigm (2008: 276). This theological argument for the inhabitation paradigm is that Christ's life and work is not there for us to copy (Louw, 2008: 276). In this paradigm, one has to live up to His gospel and the message He brought to us as the ultimate Mediator. His mediatory work cannot be repeated by mere humans. Ultimately, Louw states that: 'discipleship and imitation are pneumatological endeavours and not directly a Christological endeavour" (2008: 276). The call to discipleship and obedience should be an embodiment and enfleshment of Christ's presence through the Charisma of the Spirit; presenting the fruits of the spirit, as humans are new pneumatic beings – new beings in Christ. This formulates under a realistic approach to the theological argument. In this approach, the fruit of the spirit implies that our eschatological identity is of pneumatic ontology.

In our new ontology, one is (eschatologically) love; as love is a being function and is the fruit of the spirit - a part of our Charisma. One needs not seek love, as one must now be love because of our new Charisma. One is in this view not required to do something, but rather to be something – be the fruits of the spirit; be love (Louw, 2008: 178). This supports our argument in this chapter in a movement towards de-stigmatization. Stigma is not the determinant of our identity anymore: rather, our charisma now determines our identity (Louw, 2008: 441). One is a new pneumatic being because of Christ unconditional love, sacrifice and resurrection. Because of this, one has a new eschatological identity; a Charisma and identity of love. For this reason, one already is love and one has to love others unconditionally; unconditionally accept them and respect their human dignity and new identity in Christ.

Louw proposes that a paradigm shift is necessary to understand a pastoral approach that moves towards de-stigmatization. According to Louw, the paradigm shift involves a critique on stigmatization through the theologia resurrectionis as the theological critique (2008: 429).

HIV is a theological problem and has offered the church two possibilities (models) of theological deduction:

(a) The *Causal, Exploratory Model*: Where God is viewed as computerised in His responses. In this view of God, everything is computer programmed according to the law of providence and prediction (Louw, 2008: 428-429). In this model God is viewed as the punisher of sin and the oppressor of sinners through punishment.

(b) The *Hermeneutical, Interpretive Model*: This model is about the essence and quality of the encounter one has with God with regards to the human quest for meaning. This prompts the question regarding God's involvement in human suffering. In other words, what is God's involvement in suffering? Linking God directly with punishment can lead to inappropriate and irresponsible theologising. Louw asks; what is the more appropriate theological paradigm that we should work from in the realm of HIV and AIDS? (2008: 429).

The fundamental question in the HIV epidemic is; where is God in all this? Is punishment for sin the final and only deduction and theological paradigm one should function from, or is there an alternative? Can one move to a category of empowerment and life instead? Louw states that God cannot be discussed without the taking theological anthropology into consideration (2008: 429). The study will now consider the different theological anthropological approaches that will assist in the comprehension of the paradigm shift Louw proposes as a theological critique on stigmatization (2008: 429).

6.7 THE PARADIGM SHIFT: THEOLOGIA RESURRECTIONIS AS THEOLOGICAL CRITIQUE ON STIGMATIZATION

6.7.1 The Creational Paradigm: the Relational Creator and the Notion of Acceptance

Louw formulates a creational paradigm where human beings have the capacity for relationships and freedom (2008: 429). He argues that God is open to the joy and flourishing of creation, and is also vulnerable to the pain, viciousness and disasters (Louw, 2008: 429). The creation of the world can also be viewed as the body of God.

In this light, the argument arises that the church should use the creational approach as grounds for responding with acceptance and not with stigmatization. Acceptance is ultimately moving towards a position of avoiding judgement and an embracement of the self individually. But, the critical question still stands; if God is the creator, is he not then responsible for the creation of the virus? How does one know the virus is not the will of God? When one functions within the creational paradigm, one never moves away from the instigator question (Louw, 2008: 430).

6.7.2 The Theopaschitic Paradigm: the Compassionate and Suffering God

Parallel to the creational approach is incarnation theology which emphasises the presence of God. The quintessence of incarnation thinking is grounded in the theology of the cross (*theologia crusis)* and it functions as an attempt to prove the passion God holds for us (Louw, 2008: 430). Through Christ, God identified with our human suffering and He becomes our co-sufferer.

In this paradigm, the primary theological discussion is of passion and compassion. Suffering, even HIV related suffering, is against the will of God (Louw, 2008: 430). The response of the church should not be as the two models considered above; rather, the church should side with sufferers and the human predicament of HIV. The God-image becomes altered under this paradigm; as God is now viewed as *God-with-us* as opposed to the punishing God (Louw, 2008: 430).

The theopaschitic paradigm proves to be helpful in the comforting and counselling process of people affected by HIV and AIDS. Louw states that the theopaschitic paradigm; “enhances the notion of identification of the suffering of people with people with compassionate understanding of a divine reality” (2008: 430).

There is a problem with both the incarnation and creational paradigm that needs to be considered here: in both paradigms society is still confronted with the reality of the virus and the suffering of vulnerable at risk groups, such as women and people living in poverty (Louw, 2008: 430). The question is then; if it is true that God is so involved, why is the virus – as a reality of evil – still so prevalent? It is therefore safe to say that in both paradigms, the reality of suffering in the world cannot be ignored. Some HIV cases could be related to irresponsible and sinful behaviour, and one can therefore not

ignore the notions of guilt, sin and punishment that are intricately linked to the HIV phenomenon in theological discussions (Louw, 2008: 431).

The theology of the cross is about punishment, sin and forgiveness. But when one brings forth the notion of stigmatization, it is clear that one must move beyond the discussion of the cross, compassion, sin and punishment. The Grace of God entails more (Louw, 2008: 431).

The danger of functioning only in the discourses of sin, the cross, confession and forgiveness, is that, as a result of stigma, people living with HIV can still be haunted by the guilt feelings. Fear of rejection and anxiety is linked to the cultural and religious discourse that it is a 'sinner's disease' and linked to immoral behaviour (Louw, 2008: 431). The theological question is: how can society get rid of stigma and associations such as 'the sinner's disease' which prevail regardless of the church's proclamations of forgiveness and compassion? Theology cannot ignore judgement of sin, so how can theology move beyond a judgemental paradigm?

The compassionate perspective of the *theologia crusis* is crucial in a caring ministry; as God is indeed vulnerable and suffers with us. But, this seems to be a narrow deduction; is God not also omnipotent and able to transform our suffering realities related to HIV? Where does hope, meaning and victory fit into this (Louw, 2008: 431).

Pastoral anthropology should not restrict people to their flawed condition of being sinners, and it should not optimistically edify the human condition as possessing all the potential to rise from suffering through freedom of choice. In consideration of the HIV scenario, theology should be a theology of realism, where the resurrection faith destroys all forms of death (Louw, 2008: 432).

Louw states that stigmatization invites theology to "explore the implication of a theology of the resurrection for a theological understanding of our being human within the realm of disabilities and limitations" (2008: 432). His argument is that human beings are viewed, under the *theologia resurrectionis,* from a constructive and realistic affirmation and validation of their human identity and dignity, despite the past. Thus, people living with HIV and AIDS are sinners as much the next human being and all of humanity is affirmed and validated in identity and dignity, regardless of the past, as Christ's resurrection affirmed and validated us and not one was excluded. The resur-

rection of Christ can ultimately be viewed as God's final critique on death and suffering, human limitation and stigma (Louw, 2008: 432).

The *theologia resurrectionis* views humanity in the light of the affirmation of life and never in the light of death (destruction). Louw formulates this as the death of death: God has, in this paradigm, demolished all forms of rejection, stigma and isolation (2008: 432). In this light of this paradigm, the HIV positive person is empowered to live positively (constructively) regardless of the virus in their physical being (Louw, 2008: 432). The question in the quest for de-stigmatization is; how does one live with one's positive status in terms of realistic *hope*?

6.7.3 The Resurrection Theology: a Theology of Hope in the HIV Debate

The resurrection serves as the final proof of the divinity of Christ, but it also becomes a necessary consequence of the cross, to function in succession of the humiliation and exhalation of Christ. The resurrection forms the basis for New Testament theology in the view of its focus on transformation and the future (Louw, 2008: 434). The resurrection then functions as a central role for hope in theology; a form of indispensable base for Christian hopes in the future.

The resurrection does not only function as a hope theology, but has Christological significance too; focusing on the work of Christ and His person (Louw, 2008: 434). The necessary continuity is provided by the resurrection that Jesus was both truly human and truly divine (Louw, 2008: 434).

It can be noted that resurrection and suffering are two inseparable themes. It should be stated that resurrection is not merely an escape from suffering, rather, a new perspective of life. In other words, resurrection does not retreat from suffering' realities; it confirms the devastation of suffering (Louw, 2008: 434).

In his formulation of the theology of Hope, Moltmann describes that the resurrection is crucial in revealing of the meaning of the theology of the cross. Furthermore, Moltmann (Louw, 2000: 83) views the resurrection as opening up a future perspective, to such an extent that it obtains as eschatological superiority over the cross. Ultimately, the eschatology, as derivative of the resurrection, is the hope that is embedded in the cross. Hope is then actually resurrection hope (Louw, 2008: 434).

Therefore, the resurrection and the empty grave is God's final critique on the reality of death and every other form of death connected to the human condition, including the death of relationships and the robbing of the human dignity of people (Louw, 2008: 435).

The resurrection reality of the empty grave confirms that hope is not a mere psychological projection, but a historical revelation of God in creation: this affects the very core of death itself. This revelation implies the re-creation of creation, the re-formation and re-evaluation of embodiment and the physical. Moreover, it reveals the transforming power of God and the expression of His faithfulness despite the reality of death and suffering (Louw, 2008: 435). The resurrection summons us to a different kind of faith; the reckoning with the historical fact of the empty grave of Jesus Christ, whilst facing the extinction of death. Even in the realm of HIV, one can hope, even when the reality of death points to death as the final extinction of life (Louw, 2008: 435).

How can the pastoral counsellor encourage faith in the resurrection amongst clients who are living with and affected by HIV and AIDS? And what grounds the foundation of our eschatological hope (Louw, 2008: 436).

Louw explains that faith in the resurrection implies that our reasons for hope should not be grounded in our fear of death. In other words, one should not hope because one fears death (2008; 436). Resurrection hope is hope in spite of our anxiety. The cross and the resurrection in their interconnectedness reveal the motif of Christian hope; God's faithfulness to what He promises (Louw, 2008: 436). Resurrection confirms the following:

- The faithfulness of God
- The truth of the eschatological victory within our creaturely reality
- The transformation of disfigurement
- The affirmation that physicality is ensoulment and embodiment (Louw, 2008: 436).

Louw concludes that resurrection is the affirmation of the pneumatological reality of life and can be experienced in daily existence through hope, love, faith and peace (2008: 436). According to Louw, the process of realising resurrection life involves the expression of daily thanksgiving and praise (2008: 436). In effect, wholeness in God's creation and human existence implies a reassessment and total reframing of life. Life is now realistic; as it is full of contradictions and paradoxes, but it is now lived through the Spirit of the resurrection in hope (Louw, 2008: 436).

So how is the resurrection theology relevant in counselling people affected by and living with HIV and AIDS? What benefit does it offer to people living with HIV and AIDS? Louw provides 6 reasons why resurrection theology is beneficial:

(a) Firstly, Christ overcame death so humanity could participate in His righteousness that he won for us through His death and His resurrection. Resurrection affirms one's identity beyond stigma; as stigma is a mode of death (Louw, 2008: 436).

(b) Secondly, the resurrection empowers us to a new life; live life despite one's HIV positive status (Louw, 2008: 436).

(c) Thirdly, the resurrection is the guarantee of God's final punishment for all possible modes of sin. Therefore, humanity possesses a new freedom to live beyond labelling (the 'sinner's disease') and stigmatization. Louw states: "The notion of stigma is exchanged for charisma: life defined by the Spirit of God" (2008: 437).

(d) Fourthly, the resurrection is an affirmation of the physicality and embodiment in terms of the transfiguration of Christ's resurrected body. Thus, one's physicality does not define the value of one's existence or dignity due to one's HIV status. One is considered and affirmed as fully human despite one's HIV status defined by scientific testing (Louw, 2008: 437).

(e) Fifth, the resurrection is a promise of victory over death and therefore instils a vibrant hope in the realm of anxiety associated with death and social external stigma (Louw, 2008: 437).

(f) Lastly, Louw proposes that the resurrection restores trust in life and a new-found security. It opens up a new hermeneutics by experiencing the living God all realms of one's existence (2008: 437). Life becomes the optimal opportunity to embody the grace of God and enflesh unconditional love and acceptance, even in the realm of stigma (Louw, 2008: 437).

The *theologia resurrectionis* does not inspire ignorance to the realities of suffering. It encourages people through the struggle to find meaning in suffering. Hope is only true hope within suffering and not a fight against or from suffering, not even an attempt to sidestep suffering (Louw, 2008: 437). Resurrection abolishes all of the foundations and forms of stigma. It affirms a human identity without stigmatization. Christ's resurrection affirms and validates and identity and dignity of de-stigmatization.

Should society succeed in practically applying the *theologia resurrectionis* to one's life and use it as a practical pastoral approach to the findings of the research, one might be able to move towards de-stigmatization of condoms, sex, sexuality and HIV and AIDS. Through true affirmation, validation and acceptance of the identity and dignity of the other; the other like us has also been affirmed and validated in identity and dignity through the resurrection of Jesus Christ.

Through the resurrection, one is a new being in Christ and humanity has a new eschatological ontology. In Christ and in this new ontology, humans are endowed with the fruits of the spirit and one is therefore, because of the new eschatological ontology, love and love is now a human being function. The question is therefore not how to attain love but rather: "what are the hampering factors in one's life preventing one from exemplifying the love of God and acting out that love in all human relationships (Louw, 2008: 277)." Love, therefore, emanates from the spirit in our human bodies, the 'Charisma' of our new ontology. The challenge one now faces is to live by the spirit, carry the fruit of the spirit and be the tree that the resurrection and new pneumatological ontology enables us to be (Louw, 2008: 277). In sum, one's new eschatological identity (pneumatological ontology) enables us to be loved, as to love, and unconditionally accept and love the other without the fear of rejection. Thus, one should not let stigmatized beliefs, attitudes and prejudice influence one's acceptance and love for another. Our new identity allows us to accept others regardless of HIV status. One need not fear rejection or death, as the resurrection is one's hope for the future beyond

fear and anxiety. The resurrection gives us the ability to hope when reality points to the opposing (Louw, 2008: 435). Therefore, the resurrection de-stigmatizes all beliefs, attitudes and prejudice and enables one to live in love.

6.8 CONCLUSION

The Pragmatic task succeeds in presenting practical approaches and recommendations to guide one through the process of change towards de-stigmatization. Throughout the research, it was clear that society holds many discourses, beliefs, attitudes and prejudice about sex, sexuality, HIV and AIDS and condoms use. Throughout the hermeneutical literature review, it was proved that these perceptions contributed to a spiralling phenomenon of stigma. Through ethical reflection and theoretical discernment in the Normative task, it was determined what one's perceptions should be and the Pragmatic task assisted in exploring practical options to how we might respond to the stigma resulting from these perceptions, attitudes, beliefs and prejudices to move towards de-stigmatization thereof.

CHAPTER SEVEN:

CONCLUSION

For this research, Osmer's methodology for Practical theological enquiry was chosen. Osmer's theory stems from the foundation that Practical Theology begins with episodes, situations and contexts that call for interpretation – interpretation of the texts of life (Osmer, 2008: 12). Throughout this research, the aim was to contribute to fundamental knowledge and theory through investigation of the possible stigmatization of condom use as preventative intervention and the possible impact of this stigmatization on the HIV and AIDS epidemic humanity is faces. Osmer's methodology helps to engage in practical theological interpretation and the method comprises of four 'tasks' to interpret episodes, situations and contexts theologically (2008: 4-5).

Osmer's methodology for Practical Theology was particularly chosen for this research study as the methodology allows for an empirical, objective analysis of formal attending. The empirical component allows for formal attending to the primary research question under the descriptive empirical task, namely, what is going on? Osmer explains that objective, formal observation allows researchers to deepen their understanding of what is going on in particular episodes, situations and contexts (2008: 39). In accordance with Osmer's methodology and with relevance to this research, the empirical research in the Descriptive-Empirical task created a space for deepened understanding of what is going on with regards to the perceptions that are held about condom use. Thus, the empirical component of the epistemological endeavour proved to be particularly helpful in allowing interpretive guides to comprehend the participants in the research as it assisted in the comprehension of a trended mind-set that is impacting people's lives and shaping their context (Osmer, 2008: 41).

The four research tasks include the Descriptive-Empirical task, under which the empirical study functioned, the Interpretive task, the Normative task and finally the Pragmatic task.

The first text of interpretation, and the initiation of the first task, was the initial qualitative literature review commencing the Descriptive-Empirical task. In the initial qualitative literature review, it was determined that people do have stigmatized perceptions

about condoms and these perceptions do impact the HIV and AIDS epidemic and the stigma surrounding HIV and AIDS influences the perceptions people hold about condom use. The chapter looked at the dynamics of power, the dynamics of gender and poverty also exploring the religious and cultural influence on perceptions of condom use and HIV and AIDS.

Through special investigation into discourse and the impact of discourse on power dynamics, it was safe to deduct that discourse is a tool with which one can describe the linkage between knowledge and power. Ultimately, discourses constitute truths and produce knowledge as opposed to discovering or transmitting it (Bové, 1995: 54). Benn argues that discourses held and influenced by 3 frameworks; the scientific framework, the religious framework and the traditional framework. After investigation into these frameworks it was safe to deduct that stigmatized perceptions are based in cultural, traditional and religious world views and discourse. In other words, perceptions about condoms are influenced substantially by the beliefs and attitudes people have about condoms and HIV and AIDS. Thus, stigma is not solely a result of ignorance and poor education alone and therefore discourses and perceptual frameworks need to be thoroughly explored and assessed to develop contextually relevant educational interventions.

To support the findings in the initial literature review under the Descriptive-Empirical task, one needed to attend more closely at the attitudes and beliefs identified that impact the perceptions held about condoms. To continue with Osmer's methodology, the research study included an empirical component to the research. The empirical study was implemented to attend more formally to the topics investigated in the literature review. It further assisted in objectively supporting the findings that attitudes and beliefs influence perceptions about condoms. The additional role of the empirical study was to attend objectively and quantitatively to the matter of medically educated knowledge and the influence thereof in the processes of decision making about safer sexual practice. The empirical study affirmed the deductions of the literature review. It affirmed that educational knowledge did not have much impact on the participant's willingness to use condoms and those perceptions about condoms were in fact impacted by the attitudes and beliefs the participants held, as opposed to their educated medical knowledge thereof. The initial literature review and the empirical study revealed similar deductions

in determining what is going on with regards to the perceptions held about condoms. The empirical study completes the Descriptive-Empirical task and therefore the task as a whole succeeds in answering the question; what is going on with regards to the perceptions people have about condoms? The findings in the Descriptive-Empirical task lead to the next research question; why do these identified perceptions about condoms exist?

This question becomes the focus of the Interpretive task of the research. The Interpretive task also initiates the Hermeneutical literature review. In Chapter Four of the research, this exploration was initiated; why are condoms being stigmatized and what are the dynamics involved with stigmatization? The Interpretive task looked at the attitudes and beliefs people have about condoms, also focusing on the dynamics of stigma relative to sin, sex, sexuality and Christian discourses surrounding HIV and AIDS. It became clear throughout the Interpretive task that stigmatization can be understood as a social process and symbolic threat to society. Through drawing from other theories and engagement in rational reflection of the topic, the research determined why the identified perceptions about condoms exist. The Interpretive task succeeded in identifying that the perceptions about condoms are in fact intricately linked to the stigmas surrounding the HIV and AIDS epidemic and confirmed that HIV and AIDS is as much a socially constructed disease as a physical disease (Balcomb, 2006: 113). Stigma can therefore be understood as a complex social phenomenon and can also be context specific. Although a distinctive definition of stigmatization could not be reached, the research concluded that stigmatization should be a fundamental concern in the HIV and AIDS epidemic (Wangen 2010: 426).

The Interpretive task determined that with idealised prevention strategies grounded and paralleled to sexual morality and sexual ethics, the social process of stigmatization consequently results in a warped view of sexual prevention interventions, such as condoms and a warped view of human sex and sexuality. Wangen explains that the stigmatization of sexual prevention intervention results in their non-use, which results in extended transfer of the virus, which reinforces the stigma – and so the cycle viciously continues (2010:446).

After careful enquiry of what was going on with the perceptions of condoms and why these perceptions about condoms exist, the next research question came to light; what

ought to be going on with regards to the perceptions of condoms? In extension, this question themed the next task of the research – following Osmer's methodology - namely the Normative task. The Normative task continues with the hermeneutical literature structure to formulate the findings in Chapter Five of this research assignment. In exploration of this research question, the chapter engaged in the exploration of God's will for how humanity is to perceive sex, sexuality, HIV and AIDS and of course condoms (Osmer, 2008: 135-137). The Normative task looked at ethical principles to channel stigmatization towards moral ends. Through the use of Louw's Integrative Christian Spiritual Approach to sexual ethics, the study engaged in theological and ethical reflections on the topic of human sexuality and humanity's view of sex.

The Normative task deduced that human sexuality is a part of the human identity and therefore forms part of human dignity. Ethical and theological reflection of Louw's theory exclaimed that human beings have one ultimate need; the need to be unconditionally loved and accepted without the fear of being rejected (Louw, 2012: 87-88). Therefore, the stigma surrounding sexuality and HIV and AIDS leads to the rejection of the other and this ultimately leads to the fear of rejection, which is in all a denunciation of one's human dignity. The exploration of a new approach to human sexuality indicated that humanity's belief systems transcend the expectations and meanings humans ascribe to things. Should these beliefs and expectations not be actualised, disappointment will almost always be the result. The Normative task's ethical discernment focused on Louw's reference as he explains; should humanity succeed to look at sex, sexuality and marriage a little differently, there might be a break down the expectations and beliefs about sex, sexuality and marriage and the true purpose of sexuality, sex and marriage might be revealed. The Normative task concluded in accordance with Louw that the true purpose of sex, sexuality and marriage (space of intimacy) is the affirmation of the other. This affirmation finds confirmation in unconditional love for the other: the unconditional acceptance and love of the other, with the absence of fear of rejection (Louw, 2012: 207).

This leads to the final task in the research assignment - the Pragmatic task – as well as the final research question posed in the research assignment; how might we respond to the identified perceptions surrounding condoms? The Pragmatic task takes on a role of exploration into recommendations of a practical theological approach to move towards

a 'de'-stigmatizing of the identified stigmatized. The Pragmatic task posed numerous pastoral approaches that might assist in practically responding to the identified realities of stigmatized beliefs and attitudes. Under these practical recommendations, the Pragmatic task looked at various pastoral approaches that might assist pastoral caregiving in the challenge of moving towards de-stigmatization. The pastoral approaches included the revisit of educational awareness programmes and the reformulation thereof to become more contextually relevant to the group being educated. The Pragmatic task also looked at the pastoral care and counselling of people living with HIV and AIDS, consulting five different pastoral caregiving orientations; all with the goal of the pastoral caregiving to be geared towards the development of the inner potential of the other to bring about fuller growth, personal maturity and spiritual maturity – thus, healing the soul in order to heal life (Cura Annimarum as Cura Vitae) (Browning, 2009: 12).

The Pragmatic task concludes the chapter with the Resurrection Theology. The resurrection theology deconstructs all forms of stigmatization, as the resurrection and the empty grave can be understood as God's final critique on the reality of death – any form of death connected to the human condition. Thus, the death linked the understanding of HIV and AIDS and the death of relationships and the robbing of human dignity through stigmatization of the other, no longer function (Louw, 2008:434). Even in the realm of HIV and AIDS, there is always resurrection hope. Through the resurrection, humanity takes on a new eschatological identity that ascribes humanity to be new beings in Christ. The identity of new trees that carry the fruit of the spirit as being functions (Charisma). Amongst these fruits is the unconditional love for the other; the love, acceptance and respect of the other's being functions unconditionally, with the absence of the fear of rejection (Louw, 2008: 276-277). In other words, this unconditional love humanity possesses because of humanity's new pneumatological ontology is an affirmation of the being functions of the other; an affirmation of the human dignity of the other. This then stands against the reality of stigmatization discussed throughout the research, as stigmatization of the other contradicts the unconditional acceptance of the other. Moreover, stigmatization of the other is the disaffirmation of the other's human dignity. This concludes the theological contribution of the research.

The Pragmatic task lists Louw's six reasons as to why resurrection theology is beneficial for pastoral caregiving for people living with HIV and AIDS (see Chapter Six, page

132 of this research). The Pragmatic task concludes the investigation of the research assignment as it also concludes the Hermeneutical literature review, succeeding in presenting practical recommendations and pastoral approaches applicable to the de-stigmatization of the identified perceptions, attitudes and beliefs surrounding condoms, HIV and AIDS and sexual morality. Overall the research contributes to the field of study by showing that there is indeed clear evidence of the stigmatization of condom use amongst educated medical staff at the specific private Western Cape Hospital used in the study. The study also determined that education concerning the use of condoms does not necessarily lead to de-stigmatization thereof.

Reflecting on this research assignment with scripture, herewith an aid to the pastoral caregiver who will be challenged to move towards de-stigmatization:

“God loves you and has chosen you as his own special people. So be gentle, kind, humble, meek and patient. Put up with each other, and forgive anyone who does you wrong, just as Christ has forgiven you. Love is more important than anything else. It is what ties everything completely together. Each one of you is part of the body of Christ, and you were chosen to live together in peace. So let the peace that comes from Christ control you thoughts. And be grateful. Let the message about Christ completely fill your lives, while you use all your wisdom to teach and instruct each other. With thankful hearts, sing psalms, hymns, and spiritual songs to God. Whatever you say or do should be done in the name of the Lord Jesus, as you give thanks to God the Father because of him.” (Colossians 3:12-17).

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ADDENDUM A1: EMPIRICAL SURVEY – ENGLISH

The purpose of the study you are voluntarily participating in is to determine whether factual demographics (such as age, gender, religion, ethnicity and socioeconomic status) correlate with ideas surrounding condom use. Should correlations be found, they will be documented, recorded and ultimately explored from a practical theological and pastoral perspective.

Your participation in this study is voluntary and you are free to withdraw from you participation at any point during the research. You have also been asked to complete an informed consent form; whereby you give consent for you voluntary participation.

All data will be handled carefully by the researcher and will be kept confidential throughout the course of the research. The data recorded will be made available to a small research team consisting of the head researcher, the research supervisor and the statistical analyst. The data recorded will ensure strict procedures to enforce confidentiality and anonymity. Should any of the participants desire to access the recorded data after the successful completion of the research, they are free to do so on request to the main researcher; Tarbi Prinsloo. The researcher's information will be made available in the informed consent.

INSTRUCTIONS FOR PART 1:

Carefully read through the questionnaire. Complete the questionnaire by circling **only one** answer under each question which best suits you.

Demographic Information: (Please circle only *one* answer)

1. What is your age category?

a) >18 b) 18-21 c) 21-24 d) 24-30 e) 30<

2. What is your gender?

a) Male b) Female

3. Which ethic group do you belong to?

a) Coloured b) Indian c) Black d) Caucasian e) Other

If other, please state: _____

4. What is your home language?

a) English b) Xhosa c) Zulu d) Afrikaans e) Other

If other, please state: _____

5. Which socio-economic group do you belong to?

a) Working Class b) Working-Middle Class c) Middle Class

d) Upper-Middle Class e) Upper Class

6. What kind of area do you live in?

a) Urban b) Rural c) Formal Sub-Urban d) Informal Sub-Urban

7. What is your marital status?

a) Single b) Married c) Divorced d) Widowed

8. Which religious group do you belong to?

a) Catholic b) Jewish c) Islam d) Protestant e) Other

If Protestant, which denomination? _____

If other, please state: _____

INSTRUCTIONS FOR PART 2:

*Please circle the answer that best suits your personal views; under question 9.1 and 9.2 you are permitted to circle **one or more** answers.*

__PLEASE NOTE:__ Should you choose answer 'a' under question 9, you **ONLY need to answer question **9.2** to follow. Should you decide answer 'b' better suits you under question 9, please answer **BOTH** question **9.1 and 9.2** to follow. Should you choose answer 'c' as the option that best suits you under question 9, please complete **ONLY** question **9.1** to follow.*

9. Do you use a condom during sexual intercourse?

a. Yes, always (answer **only** question 9.2)
b. Sometimes (answer **both** question 9.1 and 9.2)
c. No, never (answer **only** question 9.1)

9.1 Why would you ***not*** use a condom?

o) My religion does not allow sex before marriage.
p) My partner will think I am cheating on him/her.
q) I am in a serially monogamous relationship.
r) Sex doesn't feel the same with a condom.
s) I am/my girlfriend is on the pill.
t) They are not that safe; they often break.
u) I'm still a virgin.
v) My religion is against contraceptives.
w) I am not in a sexual relationship at the moment.
x) Condoms are too expensive.
y) Sex with a condom is not as intimate as sex without a condom.
z) Condoms don't fit me/my partner.
aa) Condoms cause infertility.
bb) Condoms cause sexual diseases.

9.2 Why ***would*** you use a condom?

a) I am afraid of getting HIV (Human Immunodeficiency Virus).
b) I am afraid of getting an STI/STD (Sexually Transmitted Infections/Diseases).
c) I am afraid of getting (someone) pregnant.
d) It is said that "to condomise is wise".
e) I think my partner might be cheating on me.
f) I believe in safer sex all the time.
g) You get them for free; so why not?
h) Sex with a condom is just as good as sex without a condom.

ADDENDUM A2: EMPIRIESE ONDERSOEK - AFRIKAANS

Die doel van die studie waarin u vrywillig deelneem, is om te bepaal of feitelike demografieë (soos ouderdom, geslag, godsdiens, etnisiteit en sosio-ekonomiese status) korreleer met idees rondom die gebruik van kondome. Indien korrelasies gevind word, sal hulle gedokumenteer word, aangeteken en uiteindelik ondersoek word van uit 'n praktiese teologiese en pastorale perspektief.

Jou deelname aan hierdie studie word as vrywillig beskou en u is vry om jou van jou deelname in die studie te onttrek op enige punt tydens die navorsing. Daar word van jou as deelnemer geverg om 'n ingeligte toestemmings vorm te voltooi waarmee u jou ingeligte toestemming gee vir jou vrywillige deelname. Alle data sal versigtig hanteer word deur die navorser en sal vertroulik en anoniem gehou word deur die loop van die navorsing. The data sal beskikbaar gestel word vir die navorsingspan, naamlik die primêre navorser, die navorsing supervisor en die statistiese verwerker. Die data wat aangeteken word, sal met die versekering van streng prosedures anonimiteit en vertroulikheid behartig. Indien enige van die deelnemers verkies om toegang te verkry tot die aangetekende data na die suksesvolle voltooiing van die navorsing, sou hulle die vryheid hê om dit te doen op aanvraag na die hoof navorser, Tarbi Prinsloo. Die hoof navorser se informasie sal bekend gemaak word in die ingeligte toestemming vorm.

INSTRUKSIES VIR DEEL 1:

Lees deeglik deur die vraelys. Voltooi die vraelys deur **slegs een** gepaste antwoord onder elke vraag te omring.

Demografiese inligting: (Sirkel slegs *een* antwoord)

1. Onder watter ouderdomsgroep val u?

a) 18-21 b) 21-24 c) 24-30 d) 30<

2. Wat is u geslag?

a) Manlik b) Vroulik

3. Aan watter etniese groep behoort u?

a) Kleurling b) Indies c) Swart d) Blank e) Ander

Indien ander, spesifiseer: _____

4. Wat is u huistaal?

a) Engels b) Xhosa c) Zulu d) Afrikaans e) Ander

Indien ander, spesifiseer: _____

5. *Aan watter sosio-ekonomiese groep behoort u?*

a) Werkers Klas b) Werker-Middel Klas c) die Midde-Klas d) Bo-middel klas

e) Hoë Klas

6. In watter tiepe gebied woon u?

a) Stedelike b) Landelike c) Formele Sub-Stedelike d) Informele Sub-Stedelike

7. Wat is u huwelikstatus?

a) Ongetroud b) Getroud c) Geskei d) Weduwee

8. Aan watter godsdienstige groep behoort u?

a) Katolieke b) die Joodse c) Islam d) Protestantse e) Ander

Indien Protestant, wat denominasie? _____

Indien ander, spesifiseer: _____

INSTRUKSIES VIR DEEL 2:

Omring asseblief die antwoord wat die meeste met jou persoonlike menings ooreenstem. Onder vraag 9.1 en 9.2 word u toegelaat om meer as een antwoord te omring.

* **LET WEL:** *Indien u antwoord 'a' onder Vraag 9 kies, het u* ***SLEGS*** *nodig om Vraag* ***9.2*** *opvolgend te voltooi. Indien u besluit dat antwoord 'b' beter met u menings ooreenstem onder Vraag 9, voltooi asseblief* ***BEIDE*** *Vraag* ***9.1 en 9.2*** *daaropvol-*

*gend. Indien antwoord 'c' as die verkieslike opsie omring onder Vraag 9, voltooi asseblief **SLEGS** vraag **9.1** daaropvolgend.*

9. Gebruik u 'n kondoom tydens seksuele omgang?

a) Ja, altyd (Beantwoord **slegs** Vraag 9.2)
b) Soms (antwoord **beide** vrae 9.1 en 9.2)
c) Nee, nooit (antwoord **slegs** vraag 9,1)

9.1 Waarom ***sou u nie*** 'n kondoom gebruik nie?

a) My geloof laat nie voorhuwelikse seks toe nie.
b) My sexuele maat sal vermoed dat ek op hom/haar verneuk.
c) Ek is in 'n serie monogame verhouding.
d) Seks voel nie dieselfde met 'n kondoom nie.
e) Ek/my sexuele maat is op die pil.
f) Hulle is nie so veilig is nie, hulle breek dikwels.
g) Ek is nog steeds 'n maagd.
h) My godsdiens is teen voorbehoedmiddels.
i) Ek is nie op die oomblik in 'n seksuele verhouding nie.
j) Kondome is te duur.
k) Seks met 'n kondoom is nie so intiem soos seks sonder 'n kondoom nie.
l) Kondome pas my/hom nie.
m) Kondome veroorsaak onvrugbaarheid.
n) Kondome veroorsaak seksuele siektes.

9.2 Waarom ***sou u*** 'n kondoom gebruik?

a) Ek is bang vir MIV (Menslike Immuniteitsgebrekvirus).
b) Ek is bang vir 'n SOS (Sexueel oordraagbare siekte).
c) Ek is bang vir swagerskap.
d) Daar word gesê dat dit verstandig is om te "condomise".
e) Ek vermoed my seksuele maat verneuk op my.
f) Ek glo in veiliger seks; altyd.
g) Kondome word gratis verskaf, so hoekom nie?
h) Seks met 'n kondoom is net so goed soos seks sonder 'n kondoom.

ADDENDUM B: INFORMED CONSENT

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jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

Stigmatization of Condom Use amongst Educated Medical Staff: A Practical Theological Approach

You are asked to participate in a research study conducted by Tarbi Prinsloo, from the Practical Theology Department with the Faculty of Theology, at Stellenbosch University. The results recorded in this survey will be contributed to a personal MTh thesis. You were selected as a possible participant in this study because you form part of the educated medical staff from a private Western Cape hospital that has agreed to make their staff available to partake in the study.

1. PURPOSE OF THE STUDY

The study aims to determine whether there are any correlations between the factual demographic variables and the attitudinal stances participants might have towards condom use. Ultimately, if any correlations are identified, these are to be explored from a practical theological perspective and pastoral approach.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

- Carefully read the introductory paragraph and instructions at the beginning of the empirical questionnaire administered to by the primary researcher; Tarbi Prinsloo.
- Carefully read through and then answer part 1 (factual, demographic questions) of the questionnaire by circling *one answer only* that best suits you.

- Carefully read and then answer part two of the questionnaire by circling all the attitudinal answers that most accurately correlate with your opinions toward condom use.
- Hand the completed questionnaire back to the primary researcher; Tarbi Prinsloo.

Participants are to complete the questionnaire on their own at the private Western Cape hospital. The questionnaire should take no longer than 5 minutes to complete. Participants will only be required to complete the questionnaire once, where the recorded data from the questionnaire will be used for further documentation purposes in the research.

3. POTENTIAL RISKS AND DISCOMFORTS

Participation in the study holds no risks or discomforts for the participants as the completion of survey will involve circling the answers most applicable to them and will not take any longer than 5 minutes to complete. Moreover, it will be clearly communicated to the participants that they are free to withdraw their participation at any time during the study.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The participation in the study holds no potential benefits or rewards for the participants in the study as no compensation or payment will be given for their voluntary participation.

The research aims to contribute to the practical theological exploration of variables that might present correlations with the stigmatization of condom use. Hopefully, some insight regarding the use of condoms as a safer sex practice might open avenues for adapted prevention strategies pertaining to HIV and AIDS.

5. PAYMENT FOR PARTICIPATION

As stated above, no payment or compensation for participation will be given.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with the participants will remain confidential and will be disclosed only with the partici-

pant's permission or as required by law. Confidentiality will be maintained by means of strict and careful handling of data and procedures to ensure anonymity. Moreover, data will be collected and handled by the primary researcher, Tarbi Prinsloo only, and will be in the safe keeping of the primary researcher at all times. The data will be made available to the small research team, namely; the primary researcher, the research supervisor and the statistical analyst.

Data recorded in the questionnaire might be discussed in the thesis, but strict codes of confidentiality and anonymity will inevitably apply; as no names or alternate forms of identification will be made available in the thesis. Data might be reviewed by the supervision group of the primary researcher. Should any of the participants want access to the recorded data; this can be made available on request, after the research has been successfully completed.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Tarbi Prinsloo on 083 228 5590 or email at tarbi224@gmail.com. The supervisor of this research, Prof. Daniel J. Louw can be contacted on 021 808 3257 or 084 573 4322 or email at djl@sun.ac.za .

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me _____ *[the subject/the participant]* by Tarbi Prinsloo in [*Afrikaans/English]* and I am in command of this language or it was satisfactorily translated to me. I_____ was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Subject/Participant

_____

Name of Legal Representative (if applicable)

_____ _____

Signature of Subject/Participant or Legal Representative Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant]*. *[He/she*] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/English*] and no translator was used.

Signature: _____ **Date:** _____

ADDENDUM C: NETCARE CONSENT LETTER

Netcare N1 City Hospital

Louwtjie Rothman Street, Goodwood, 7460
P O Box 12581, Goodwood, 7463
Tel: +27 (0) 21 590 4444
Fax: +27 (0) 21 595 2304
www.netcare.co.za

7 Graniet Street
Stellenridge
Bellville
7530

06 August 2012

Dear Tarbi

HIV Awareness Training / Research

This is just a short letter of sincere appreciation for the HIV Awareness Training you have done with our staff members thus far.

We know that you are currently doing your thesis and herewith give you consent to use Netcare N1 City Hospital staff members as part of your sample in order to conduct your research study. We are happy for you to hand out questionnaires to the staff members who voluntarily subject themselves to partake in your research.

We wish you much success with your M degree studies.

Kind Regards

Ines Krüger
HR Manager
Netcare N1 City Hospital

Ines.kruger@netcare.co.za

Netcare Hospitals (Pty) Ltd T/A Netcare N1 City Hospital
Directors:
J Du Plessis, R H Friedland, I Soomra
Company Secretary: L Bagwandeen Reg. No. 1996/006591/07

ADDENDUM D: ETHICAL CLEARANCE LETTER

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Approved with Stipulations
New Application

08-Oct-2012
Prinsloo, Tarbi T
Stellenbosch, WC

Protocol #: **Desc_Prinsloo2012**
Title: **Stigmatization of Condom Use amongst Educated Medical Staff: A practical Theological Approach**

Dear MS Tarbi Prinsloo,

The **New Application** received on **17-Sep-2012**, was reviewed by Research Ethics Committee: Human Research (Humanities) via Committee Review procedures on **27-Sep-2012**.

Please note the following information about your approved research protocol:

Protocol Approval Period: **27-Sep-2012 -26-Sep-2013**

Present Committee Members:
De Villiers, Mare MRH
De Villiers-Botha, Tanya T
Gorgens, Gina G
Gunter, Elizabeth E
Hansen, Leonard LD
Horn, Lynette LM
Mostert, Paul PJ
Newmark, Rona R
Prozesky, Heidi HE
Somhlaba, Ncebazakhe NZ
Theron, Carl CC
Van Wyk, Berte B
Van Zyl, Gerhard G
Viviers, Suzette S

The Stipulations of your ethics approval are as follows:
DESC and Application form:
DESC Application form: Section i) 6i—The researcher indicates that the instrument(s) that will be used to gather data are not in the public domain; however, no mention is made of whether or not permission has been/will be obtained to use the instrument(s). If it is the case that such instruments will be used, please request permission to use them from the appropriate person/body and submit the letter to the REC.
Section iii) 6k—the researcher indicates that the data will be kept "safely" with her "personal files". This does not describe the measures that will be taken to protect data. Please elaborate on the measures in place to protect data in more detail.
Section (iv) A description is needed of what will happen to the data after the completion of the research.
In a letter to the REC please explain to what information is referred to in par. 2(c) - obtained from government departments, NGO's, etc. and NOT in the public domain. Same applies to 6(n) - access to archival data.
Par. 6(j) measuring instruments (questionnaires) are in the public domain.
Research Proposal:
1) It is indicated that the questionnaires will be administered anonymously; however, no detail is given on how this will be achieved. Please note that distributing and collecting questionnaires from a group of participants does not in itself constitute anonymity. The REC recommends that the questionnaires be deposited into a sealed box by participant to ensure that they cannot be linked to their specific questionnaires.
Participant Information Sheet:
There are spelling and grammatical errors in the Participant Information Sheet/Questionnaire (in both the Afrikaans and English versions). Please have these corrected before administering the questionnaire.
Informed Consent Form:

1) The Research Proposal states that the research participants will primarily be Afrikaans and English. However, no Afrikaans Informed Consent Form is provided. Please ensure that such a document is available. The REC also recommends that provision be made for participants who are not proficient in Afrikaans and English, as language may be a barrier to their participation.
2) Reference is made to "the HIV Awareness Training you have done with our staff members thus far." For the sake of clarity, in a letter to the REC please explain what this refers to and in what capacity this was done, i.e. whether this formed part of your research as a US student researcher.
3) Please rephrase par. 2. Language is too scientific and should be in more user-friendly language: e.g. "factual demographic variables"; "attitudinal stances"; "correlations identified".
Please add that the identity of the institution where the research will be protected and that it will only be described in generic terms (a private hospital in the Western Cape).

Standard provisions

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.

You may commence with your research with strict adherence to the abovementioned provisions and stipulations.

Please remember to use your **protocol number** (**Desc_Prinsloo2012**) on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required.

The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) number REC-050411-032.

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981).
Research that will be conducted at any tertiary academic institution requires approval from the relevant parties. For approvals from the Western Cape Education Department, contact Dr AT Wyngaard (awyngaar@pgwc.gov.za, Tel: 0214769272, Fax: 0865902282, http://wced.wcape.gov.za).

Institutional permission from academic institutions for students, staff & alumni. This institutional permission should be obtained before submitting an application for ethics clearance to the REC.
Please note that informed consent from participants can only be obtained after ethics approval has been granted. It is your responsibility as researcher to keep signed informed consent forms for inspection for the duration of the research.

We wish you the best as you conduct your research.
If you have any questions or need further help, please contact the REC office at 0218089183.

Included Documents:
consent forms
Research frame work
Research schedule
research proposal
permission letter
Research framework
application

Sincerely,

Susara Oberholzer
REC Coordinator
Research Ethics Committee: Human Research (Humanities)

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2.Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4.Continuing Review. The REC must review and approve all REC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7.Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.Reports to Sponsor. When you submit the required reports to your sponsor, you **must** provide a copy of that report to the REC. You may submit the report at the time of continuing REC review.

9.Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognized as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

10.Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

11.On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.